

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Legal Name _____

Date of Birth _____ Social Security # _____

Previous Name _____

Address: _____

City _____ State _____ Zip _____

I request a copy of my medical record as held by:

Office of _____

Fax Number: _____

Please mail the following records (check one)

- Full Medical Record
- Medical record for period _____ through _____
- For the following treatment or conditions: _____

Records requested by: (print name) _____

Address (If other than patient): _____

Please mail records to: *Hawaii Family Physicians
P O Box 2060
Kealahou, HI 96750*

Other: _____

I, the undersigned, understand I am authorizing the release of any medical information regarding the above patient as might be necessary to provide and administer optimum, continuing health care and that this may include information relative to substance abuse, HIV status, sexually transmitted diseases, mental conditions and/or other confidential information.

I understand that, unless otherwise provided by law, the charge for this record is a minimum of \$5.00 plus \$0.25 per page for each additional page over 20. I agree to pay this charge in full at the time I receive the copy of the record if for personal records.

Signature: _____ Date _____

Relationship if other than patient _____

Witness _____ Date _____