Hawaii Family Physicians

75-5870 Walua Rd. #200 Kailua-Kona, HI 96740 p:808-323-3107 f:808-323-0012

David Arthurs, DO Beth Catanzaro, MD Nathan King, MD John Littleton, PAC Marie Thomas, PAC Hannah Montanye, PAC

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Legal Name: _____Date of Birth: _____

Previous Name: _____Phone Number: _____

Address: _____

City _____ State_____ Zip _____

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

✓ **Office of:** _____

Fax Number: _____

Please release the following records:

✓ Vaccination and Medication History

✓ Cancer screenings: ✔Colorectal (colonoscopy) ✔Cervical (pap) ✔Breast (mammo)

✓ Labs and/or Pathology to support cancer screening findings

Further records to be requested later as indicated by Medical Provider

✓ **Please release records by <u>Secure Fax</u> to: Hawaii Family Physicians: <u>808-323-0012</u>**

or ❒ Mail to: 75-5870 Walua Rd. #200
Kailua-Kona, HI 96740

Other: _____

❒ **Records to be released to office of:** _____

Fax number or address: _____

I, the undersigned, understand that by signing below I am authorizing the release of any medical information regarding the above 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 agree to pay this charge in full at the time I receive the copy of the record if for personal records. I understand that, unless otherwise provided by law the charge for this record is a minimum of $10.00 plus $0.25 per page. I understand I have the right to revoke this Authorization at any time. This Authorization will expire on the earlier of _____ (date) or two years after my death.

Signature: _____Date _____

Relationship if other than patient _____

Witness _____ Date _____