

**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 \_\_\_\_\_