**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:**

❒ **Hawaii Family Physicians**

**Please release the following records:**

Vaccination History ❒ and/or Medication History❒

Cancer screenings: Colorectal (colonoscopy)❒ Cervical (pap)❒ Breast (mammo)❒

Provider Visit Notes for period: through

Labs/Pathology reports:

Hospital Records/Consultations:

Xray reports or Diagnostic tests:

For the following treatment or conditions:

❒ **Please release records by Secure Fax to: Hawaii Family Physicians: 808-323-0012 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