KIHEI-WAILEA MEDICAL CENTER
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□ Dr. Gayland Yee □ Dr. Kenneth Kepler □ Dr. Linda Tetor
□ Dr. Sarah See □ Dr. Dane Kurohara □ Dr. Stephen Daly
□ Justin Ody PA-C □ Brooke Hayes PA-C
□ Merika Hunter PA-C **ACCEPTED BY (INITIAL): _____**

AUTHORIZATION FOR THE RELEASE OF PROTECTED MEDICAL INFORMATION

Patient Information:

_____ _____ _____
Last Name, First Name, M.I Date of Birth Phone number

_____ _____ _____
Street Address City, State Zip code

Is this patient a child?_____ If yes, print name off parent/guardian _____

What information are you requesting?

□ Full Chart □ Last__ office Notes □Last Mammogram Report
□Last Diabetic Eye Exam □Immunizations □Growth Charts
□Last PAP/HPV report □ Last Bone Density Test □ Last EKG/ Echo/ Stress Test
□ Lab Results Within Last Year
□ Last Endoscopy/ EGD/ Colonoscopy/ Sigmoidoscopy/ Fecal Test & include pathology
□Other Radiology Report: _____
□Other: _____

What would you like to do with your records?

☐ **Send** my records to:
_____ Phone: _____
_____ Fax: _____
_____

☐ **Obtain** my records from**:**
_____ Phone: _____
_____ Fax: _____
_____

☐ **Download** my records for my personal possession*

* Copies made for patient's personal possession will cost a flat fee of $25.00. There is NO charge if sent to another physician.

NOTE: I hereby authorize Kihei-Wailea Medical center to release any medical information as requested above. Any and all information regarding the above described individual including, but not limited to; all medical records; other records; notes; incidence; occurrence; or other reports; test results; referrals; memoranda; correspondence; photographs, x-ray, CT and MRI films; bills; invoices, accountings, statements of charge, and all insurance-related documents ("information") Information will not be released without a valid signature below. This authorization will expire 90 days from the signature date. I can however, cancel this authorization in writing at any time, except to the extent that Kihei-Wailea Medical center has relied upon it. I understand that specific consent may be required to release such information and hereby give such specific regulations restricting the release use and dissemination of the information.

X _____ _____/_____/_____
Patient Signature Date

_____ _____/_____/_____
Signature of parent/guardian if patient is a minor (ages 0-17) Date

FOR OFFICE USE ONLY
Date Completed: _____
Action taken: Mailed Faxed Picked Up Pending (circle one)
Unable to locate chart
Prepared by: _____