KIHEI-WAILEA MEDICAL CENTER
221 PIIKEA AVE, STE A KIHEI, HI 96753
PH (808) 874-8100
FX (808) 874-6887

OBTAINING RECORDS

FOR OFFICE USE ONLY

DATE RECEIVED:_____

RECEIVED BY:_____

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? Y / N If yes, print name of parent/guardian & relation: _____

What information are you requesting? :

□ Last _____Office Notes
□ Chart (FROM 2017-CURRENT)
□ Immunizations
□ Growth Charts
□ Lab Results within Last Year
□ Last PAP/HPV report
□ Last EKG / Echo / Stress Test
□ Last Diabetic Eye Exam
□ Last Bone Density Test
□ Last Mammogram Report
□ Last Endoscopy / EGD / Colonoscopy / Sigmoidoscopy / Fecal Test & include Pathology
□ Other:_____

What would you like to do with your records? :

☐ OBTAIN my records from:

I hereby authorize the below listed to release records to Kihei Wailea Medical Center*:

_____

_____

_____

_____

_____

*Please send records via fax to 808.874.6887 (preferred) or mail to:
Kihei-Wailea Medical Center ATTN: Medical Records , 221 Piikea Ave. Ste A, Kihei, Hi. 96753.
If you are mailing records please fax with status to avoid follow up calls/fax.

Purpose of Release:

□ Transferring Care □ Personal □ Insurance □ Legal □ School □ Other _____

X _____
Patient Signature Date

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

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 one (1) year 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