Kapolei Family Medical Center, Inc.
590 Farrington Hwy, 526A
Kapolei, HI 96707
Phone: 808-674-2930 / Fax: 808-674-2950

Release of Medical Records

From: (Previous Doctor 's Information)
Name:_____
Address: _____
Phone:_____ Fax:_____

To: (Please circle Primary Care Provider)
Jonathan Kim, MD Tracie Hata, MD
Larissa Wong, DO Karolyn Lam, DO

I hereby authorize the use of disclosure of my individually identifiable health information as described below.

Patient name: _____ Date of Birth_____

Address: _____

Telephone: Home/Cell: _____ Work: _____ SSN _____

This authorization covers the period from date's _____ to _____
Please send a copy of: Select from the following (check as many as apply)

Complete Record ____	Progress Note _____	X-ray reports _____
Discharge Summary ___	History and PE _____	Lab reports _____
Pathology reports ____	ER records _____	Consult report ____
Surgery reports _____	billing records ____	

Other: _____
Note Release of psychotherapy notes, as defined by HIPAA regulations, requires a separate authorization

If my records contain any information about:
Aids or HIV infection or venereal disease _____ treatment for alcohol and/or drug abuse _____
Mental health or psychiatric services _____
I DO ____ or I DO NOT____ authorize the release of this information. Initials _____

This information is to be disclosed for the purpose of Continuing health care ____ or Legal Purpose ____
Other (specify) _____

I understand that if the organization authorized to receive this information is not a Health Plan or Health Care Provider, the release of information may NO longer be protected by federal privacy regulations. The Kapolei Family Medical Center, Inc., its employees, officers and health care providers are released from any legal responsibility or liability for releasing the requested information as authorized.
The patient or the patient's representative must be ready and initial the following statements:
I understand that this authorization will EXPIRE on _____ or upon the following event or condition _____ unless revoked. Initials _____
I understand that I may revoke this authorization at any time by notifying this facility in writing. I also understand that revoking this authorization will not apply to any information released by this facility before they received the revocation.

Signature _____ Print Name _____ Date _____
IF SIGNED BY SOMEONE OTHER THAN THE PATIENT, PLEASE IDENTIFY YOUR AUTHORITY TO ACT ON BEHALF OF THE PATIENT.