Functional Medicine of Hawaii
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PERMISSION TO RELEASE MEDICAL RECORDS

1. Patient's Name
_____

2. Date of Birth _____

Permission is hereby granted for release of information

3. From:

Name _____
Medical Provider Holding Records

Address _____
_____

4. To:

Name _____
Address _____
_____

5. The purpose of the release is:
_____

Transfer of care _____ yes ___ no

6. The following information may be released.
_____
_____
_____
_____

7. For the following dates of service: From _____ Through
_____

8.This permission expires six months from the date signed or
_____ Specified Expiration Date

Required _____Initial

***I do___ do not ___ specifically consent to transmission of my medical records via a facsimile (fax) machine.

Initial in spaces provided
____ I recognize that the information disclosed may contain drug/alcohol information that is protected by federal and

____ state law. I specifically consent to disclosure of such information.
____ I recognize that the information disclosed may contain mental health information that is protected by federal

____ and state law; I specifically consent to disclosure of such information.
____ I recognize that the information disclosed may contain information regarding sexually transmitted diseases or

____ HIV/AIDS testing information. I consent to disclosure of such information.
____ Please note there will be a charge of .50 / pg. for pgs. 1-50 and .15 / pg. thereafter for copy requests.

9. _____ Signature of Patient or Representative

10. _____ Date Signed

_____ Relationship (if signed by the representative)

_____ Witness (optional)