Authorization to Release Medical Records/Information

579 Farrington Highway Suite 204
Kapolei, HI 96707
Phone (808) 674-4300
Fax (877) 643-2648 or (888)723-2279

Patient's name: _____ SSN: _____-_____-_____ DOB: ____-____-____	
Name (Facility or Doctor) & Address to provide records:	Name & Address to receive records: **Graeme Reed, MD** **The Family Doctor, LLC** **579 Farrington Highway Ste 204** **Kapolei, HI 96707** **Ph: 808-674-4300 Fax: 888-723-2279** **If possible, pls. send electronic records in PDF format**

I authorize the release of the information specified below.
Release these records:

Initials

_____ 1. Only records generated by this facility (not including records received from other sources)

_____ 2. Only some portion of records maintained at facility (specify below)

_____ 3. All medical records at this facility

_____ 4. Other: _____

I specifically authorize the release of information regarding the following condition(s):

Initials

_____ Drug abuse if any
_____ Substance abuse if any
_____ Psychological or psychiatric conditions if any
_____ AIDS/HIV if any

Expiration or revocation of authorization -- I understand that I may revoke this authorization at any time.

Use of copies -- A copy of this authorization may be utilized with the same effectiveness as an original.

_____ _____
Patient's Name (Print) Patient's Signature Date

_____ _____ _____
Person Authorized to Sign for Patient (Print) Relationship Authorized Signature Date

Based upon COPIC Form at http://www.copic.com/guidance/release.htm Updated: 11 November 2011