Kauai Community Health Alliance
Dba: Hale Le’a Medicine
(808)828-2885/ Fax: (808)828-0119
Email: hlmstaff@kauai-medical.org

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME: ____DATE OF BIRTH: ______________

ADDRESS: ____PHONE NUMBER: ________________

CITY: ____________________________STATE: __________________________ZIP: ______________

I, the undersigned, hereby authorize:

HALE LE’A MEDICINE
2460 OKA ST #101A, KILAUEA, HI 96754
PHONE: **(808)828-2885** FAX: **(808)828-0119**

To disclose records in the course of my diagnosis and treatment to include:

___Medical
___Psychiatric/Psychological
___Laboratory
___Medication List
___Imaging
___School Records
___Immunizations
___Other:_____________________

*To disclose data pertinent to your treatment of me from*______________*to*_____________.

To be released to:

NAME: ____

ADDRESS: ____

CITY: __________________STATE: ____________ZIP: ____________

PHONE: __________________FAX: __________________

NOTE: Many Primary Care Providers (PCPs) will request medical records directly from the patient’s prior PCP. If so, you can complete their form or provide this form to your new PCP/facility.

Please check the appropriate box (boxes) below:

☐ Please electronically send records to the PCP/facility listed above.

☐ I would like a copy emailed to me at this address____.
I acknowledge and accept the risk that my email account may not be secure or private.

Signature: ____*Date:* ______________________

Witness: ____*Date:* ______________________

Please email a signed copy of this form to hlmstaff@kauai-medical.org.
Please continue to check our website for updates. (kauai-medical.org)