REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT Name: _____

Address: _____

Date of Birth: _____

I hereby authorize and request that my records be released from:

Sarah Canyon, MD PhD
328 Uluniu Street
Suite 103
Kailua, HI 96734
Phone: 808-451-0555
Fax: 808-762-1586

I hereby authorize and request that my records be released to:

Physician Name: _____

Address: _____

Phone: _____

Fax: _____

Please indicate if you do not wish any of the following records to be released:

- Mental Health treatment records, inclusive dates _____to_____
- Drugs and/or Alcohol dependency records, inclusive dates _____to_____
- Other: _____

_____ _____

Signature of patient or legal representative **Date**