SLEEP CENTER HAWAII

Aiea
99-128 Aiea Heights Dr #101
Aiea, HI 96701

Kailua Kona
75-167 Kalani St #205
Kailua Kona, HI 96740

Hilo
56 Kamehameha Ave
Hilo, HI 96720

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the physicians and staff of:

Clinic Name:
Address:
Phone:
Fax:

to release information from my medical record to Sleep Center Hawaii. The purpose of this request is for medical care.

Information to be released:

☐ History and Physical
☐ Consultation
☐ Questionnaires
☐ Progress Notes
☐ Physician's Orders
☐ Sleep Study Reports
☐ Laboratory
☐ EKG
☐ Other: _____
_____

Name of Patient:
Name at the time of treatment:
Date of Birth:
Telephone Number:
Address:

This authorization may be revoked by the patient verbally or in writing at any time, but not made retroactive to any information already released with authorization.

Signature of Patient or Legal Guardian Date

Print Name of Patient Print Name of Legal Guardian (if applicable)

This information has been disclosed from records whose confidentiality may be protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibit medical providers from making further disclosure of this information except with the expressed, written consent of the person to whom it pertains. A general authorization to release of information, if held by another party, is insufficient for this purpose.