PATTI K.MURAKAMI ENDO, M.D.

DIPLOMATE AMERICAN BOARD OF DERMATOLOGY
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REQUEST RECORDS RELEASE FORM
Sending Dr. Endo records to Outside Dr/Clinic

Patient Name:_____ **Date of Birth:**_____
Legal Last Name First Name Middle Initial

List any other name(s) you may go by: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary/narrative of my protected health information (PHI) to the physician/facility/entity/person listed below.

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records.
INITIAL:_____ **DATE:** _____

Release my protected health information from Patti K.M. Endo, M.D. to the following physician/facility/entity/person:

Name:_____

Telephone Number: (____)_____ **Fax Number:** (____)_____

Address:_____

City: _____ **State:** _____ **Zip Code:** _____

Information to be released subject to this signed release:

☐ Complete Records ☐ History & Physical ☐ Progress Notes ☐ Care Plan ☐ Lab Reports
☐ Hospital Reports ☐ Pathology Reports ☐ Radiology Reports ☐ Treatment Records
☐ Operative Reports ☐ Medication Records ☐ Other: _____

The purpose /reason for this release is as follows:

☐ Transfer of Care ☐ Relocating/ed Off Island ☐ Continued Care ☐ Self/Personal records ☐ Other: _____

(If a fee is required, the office staff will completed the section below)
□ There is a$15.00 records fee payable to Patti Endo, M.D. (payable by check or credit card)
Fee must be paid before we process/release your records

□ Check #: _____ □ MasterCard or Visa: _____
Last 4 digits Expiration Date CVV code

I understand that Patti K.M. Endo, M.D., will provide this information in approximately 7-10 business days from their receipt of my originally signed form, and that if noted above, there may be a fee for preparing and furnishing my protected health information.

SIGNATURE:

_____
PRINTED Patient Name

_____ _____
SIGNATURE of ☐Patient, or Patient Representative ☐ POA ☐ Parent ☐ Other Date Signed

For Office Staff Completion Only

Date Request Mailed☐ Faxed☐: Signed Request Received:

Records Mailed☐ Faxed☐ Picked Up☐: Dr. Endo- Auth to release: