PATTI K.MURAKAMI ENDO, M.D.

DIPLOMATE AMERICAN BOARD OF DERMATOLOGY
1830 Wells Street Suite #102, Wailuku, Hawaii 96793
Telephone (808) 877-3635

MEDICAL RECORDS RELEASE FORM-
Requesting records from 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:** _____

REQUESTING RECORDS FROM physician/facility/entity/person

Name:_____

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

Address:_____

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

Please mail my protected health information to the following physician:

Name: PATTI K.M ENDO, M.D., INC.
Telephone Number: (808) 877-3635

1830 WELLS STREET, SUITE 102 WAILUKU, HAWAII 96793-2365

Information to be released:

☐ 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 ☐ Continued Care ☐ Self/Personal records ☐ Other: _____

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: