FRANK R. BAUM, M.D., INC.
Pediatrics and Adolescent Medicine

200-1 Kalepa Place
Kahului, Maui, Hawaii 96732
Telephone: (808) 871-7116
Fax: (808) 877-4134

AUTHORIZATION FOR RELEASE/ DISCLOSURE OF MEDICAL RECORDS/HEALTH INFORMATION

PATIENT'S NAME: _____ BIRTH DATE: _____

I HEREBY AUTHORIZE AND RELEASE OF RECORDS:

TO: (check one) FROM:

[__] FRANK R. BAUM, M.D., INC. _____
200 KALEPA PLACE _____
KAHULUI, HI 96732-2471 _____

OR

FROM: TO:

[__] FRANK R. BAUM, M.D., INC. _____
200 KALEPA PLACE _____
KAHULUI, HI 96732-2471 _____

Telephone/Fax: _____

YOU MAY DISCLOSE THE FOLLOWING HEALTH CARE INFORMATION:

[__] All of my child's health information

[__] My child's health information relating to the following treatment or condition:

_____

[__] My child's health information for the date(s): _____

[__] Other (Please specify): _____

THIS AUTHORIZATION ENDS ON: (Date) _____/_____/_____

_____ _____
Signature (Responsible Party) Relationship to Patient

_____
Print Name (First and Last)

Signature of Witness: _____ Date: _____

Frank R. Baum, M.D., Inc. will release only one copy of medical records at no charge with this signed request. There will be a $25.00 fee charged for each subsequent copy requested.