PANIOLO PEDIATRIC AND FAMILY MEDICINE INC.

Kamuela Office
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Kona Office
75-170 Hualalai Rd suite D214
Kailua Kona, Hi 96740
Ph: (808) 325-5805 Fax: (808) 657-4796

I hereby authorize: _____

Phone: _____

Fax: _____

To release my medical records.

Please limit records to problem summary sheet & other pertinent notes, results, etc. also please include <u>all</u> Well Exams & <u>all</u> Immunization records from current and all previous physicians.

To: PANIOLO PEDIATRIC AND FAMILY MEDICINE INC.
Brett Ferguson, M.D., Steven Kaplan, M.D., Peter Gregg, M.D.,
Melissa Pulling, MD., Will Chapple, MD., Jon Ishii, MD.,
Meghan Gallagher, CPNP, Neeva Lemmel-Duerr, CPNP,
Melissa Perrin- Hernandez, M.D., Jennifer Shotwell, CPNP

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

_____ _____
Patient Name (Print Last, First, Middle Initial) Date of Birth

_____ _____
Signature (Parent or Guardian if Patient Is Under 18) Today's Date

Patient Rights:

- I have the right to revoke this authorization at any time by contacting this office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed.
- Information disclosed as a result of this authorization may be subject to redisclosure by the recipient.
- I understand released information may include a communicable disease diagnosis such as HIV.