Request for Release of MEDICAL RECORDS

Date: _____

Name: _____
LAST FIRST MIDDLE

Date of Birth: _____ / _____ / _____

To: _____
NAME

_____
ADDRESS

_____
CITY STATE ZIP

_____ _____
PHONE NUMBER FAX NUMBER

I hereby request that my Medical Records to be released to

Vinson K. Diep, M.D.
NAME

Kapiolani Medical Center for Women & Children
1319 Punahou Street, Suite 1190
ADDRESS

Honolulu HI 96826
CITY STATE ZIP

(808) 945-9955 (808) 945-9988
PHONE NUMBER FAX NUMBER

Signature: _____
PATIENT, PARENT OR GUARDIAN