

## **Request for Release of MEDICAL RECORDS**

	Date:	
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LAST	FIRST	MIDDLE
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o:		
	NAME	
	ADDRESS	
CITY	STATE	ZIP
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PHONE NUMBER  I hereby request to k  Vinse  Kapiolani Medical 1319 Puna	t that my I be released on K. Diep, NAME Center for Value of Street, Address	FAX NUMBER  Medical Records  I to  M.D.  Women & Children Suite 1190
PHONE NUMBER  I hereby request to to Vinse  Kapiolani Medical 1319 Puna  Honolulu	that my Inches that my Inches released to the second street, address the se	FAX NUMBER  Medical Records  I to  M.D.  Women & Children Suite 1190

PATIENT, PARENT OR GUARDIAN