WINDWARD ORTHOPAEDIC GROUP, INC

Kailua Professional Center
30 Aulike St, Ste 201
Kailua, HI 96734
Phone: (808) 261-4658
Fax: (808) 263-2036

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO: _____ **FROM: _____**
Phone: _____ **Phone: _____**
Fax: _____ **Fax: _____**

I, hereby authorize Windward Orthopaedic Group, Inc to *(check one)*:
_____ Release to _____ Obtain from

Name: _____

Address: _____

Phone: _____ **Fax:** _____

REGARDING: **Patient Name: _____**
Date of Birth: _____
Treatment Dates from: _____ to _____

Check all that apply:

- ❑ Chart/Progress Notes: _____
- ❑ X-Ray Film/Disk _____
- ❑ Operative Reports: _____
- ❑ All Records _____
- ❑ Other (Please specify): _____

Purpose (check one) : _____ Continued Care _____ Legal Reasons _____ Personal

_____ Other: _____

I understand this authorization is voluntary and that I may revoke this authorization at any time, in writing. This authorization will remain in effect for one (1) year from the date signed. I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy regulations.

Signature: _____ **Date: _____**

Print (if other than patient): _____ **Relationship to patient: _____**