



*73-5618 Maiau Street, Suite A204
Kailua-Kona, HI 96740
Tel: (808) 329-1146
Fax: (808) 326-2871*

Medical Records Request

TO: _____

I request a copy or summary of the following Medical Records.

- Complete Medical Record
- Biopsy Report(s)
- Lab Report(s)
- Consultation Report(s)
- Medication Allergies
- Allergy Test/Treatment
- Surgical Procedures
- Other: _____

For dates of Service from _____ to _____

Additional
Comments: _____

This request will expire one (1) year from the date of signature.

Patient
Name: _____ DOB: ___/___/___

Patient
Signature: _____ Date: _____

Witness: _____