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Kailua Kona, Hawaii 96740
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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 reports(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____