RECORD RELEASE AUTHORIZATION

TO:____
DOCTOR OR HOSPITAL

____
ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

Hawaii Compassionate Care - Kevin Baiko MD
4-831 Kuhio Highway Suite 438-300
Kapaa, HI 96746
Phone:808-854-6335 Fax: 808-443-0369
Email: records@hicompassionatecare.com

THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD

FROM____________________TO__________________

NAME____DATE____________

ADDRESS____

SIGNATURE____
(IF RELATIVE, STATE RELATIONSHIP)

PHONE____