Celeste Adrian, M.D.
Stellar Women's Health Specialists
30 N. Church Street, Suite 300
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Telephone (808) 242-9787
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Authorization for Release of Medical Information

Patient Name: _____
Last First MI Maiden or other name

Date of Birth: _____ SS Number: _____ - _____ - _____ Telephone:_____
Month/Day/Year

I hereby authorize STELLAR WOMEN'S HEALTH SPECIALISTS, CELESTE ADRIAN, MD, LLC., to release medical information to:

Name: _____

Address: _____ City: _____ State: _____ Zip code: _____

Phone: _____ Fax: _____

Information to be released:

____ **ALL RECORDS** or (please mark all that apply)
____ History of Physical Exam ☐ Progress Notes ☐ Lab Reports ☐ X-ray reports
____ Other: _____

I understand that this authorization will expire ninety (90) days after signing this form.

I understand that if this person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, this information described may be redisclosed and is no longer protected by Federal privacy regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain medical treatment or payment for my eligible benefits.

I understand that I may revoke this authorization at any time by putting my request in writing to Celeste Adrian, MD., except to the extent that action has already been taken as directed by me by this authorization.

I understand that I will pay of fee of 10 cents per page for those records exceeding 10 pages, with the exception of those records that will be sent directly to the facility of ongoing care or follow-up treatment per the request of the referring physician.

I understand that in compliance with Hawaii State statute, Stellar Women's Health Specialists, Celeste Adrian, MD, LLC., has 10 business days to prepare the records requested.

_____ _____ OR _____ _____
Signature of Patient Date Parent/Legal Guardian/Authorized Person Date