Authorization to Obtain Medical Information

Patient Name: _____
Last First MI Maiden or other name

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

Address: _____ City: _____ Zip code: _____

Day Phone: _____ Evening Phone: _____

I hereby authorize:

Name: _____

Address: _____ City: _____ Zip code: _____

Phone: _____ Fax: _____

Information to be released:

- ☐ History of physical exam
- ☐ Progress notes
- ☐ Lab reports
- ☐ X-ray reports
- ☐ Other: _____

Information to be released to:

Celeste Adrian, M.D.
Stellar Women's Health Specialists
30 N. Church Street, Suite 300
Wailuku, HI 96793
Telephone (808) 242-9787
Fax (888) 972-5617

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

I understand that I may revoke this authorization at any time by contacting the providing organization in writing and it will be effective on the date notified with the exception to the action that has been taken on it already.

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