REIS PEDIATRICS
KAILUA PROFESSIONAL CENTER I | 30 AULIKE ST, SUITE 500, KAILUA, HI 96734 | 808.263.8822
WWW.REISPEDIATRICS.COM

RECORDS RELEASE AUTHORIZATION (INCOMING PATIENTS)

I AUTHORIZE:

Name of Healthcare Provider: _____

Address: _____

Telephone Number: _____

Fax Number: _____

TO RELEASE PROTECTED HEALTH INFORMATION TO:

REIS PEDIATRICS
30 Aulike Street, Suite 500
Kailua, HI 96734
808-263-8822
Fax 808-261-6749

PLEASE SEND:

___ All Healthcare Information

___ Immunization, growth, well visits only.

___ Immunization Record Only

___ Consultation Note(s) Date(s) _____

For the following patients:

Child/children's name(s) and date(s) of birth: _____

_____

Parent's name: _____

Address: _____

Phone number: _____

Signature: _____ Date: _____

This Authorization will expire 90 days after the date identified above. You can cancel this authorization at any time, but you must do so in writing. If you cancel it, the people authorized to use and disclose your protected health information may use the information collected prior to the date you revoked this authorization. Please send written revocation to the individual or department who you authorized to use your protected health information. Also, please be aware that once we disclose this information per your instructions, the information is subject to re-disclosure and may no longer be protected.

NOTE: WHEN THIS FORM IS COMPLETED, PLEASE DO NOT SEND IT TO REIS PEDIATRICS. MAIL THIS FORM TO YOUR PREVIOUS DOCTOR TO HAVE THE RECORDS COPIED AND SENT TO OUR OFFICE. THANK YOU.