Curtis Takemoto-Gentile, M.D.
Krishanna Takemoto-Gentile, M.D.

CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name_____ Date of Birth ____/____/___

Requesting Records from : _____

Address:_____

Phone number:_____ Fax number: _____

I hereby authorize that my medical records be released to:

Curtis Takemoto-Gentile, M.D.
Krishanna Takemoto-Gentile, M.D.
2632 S. King St, Honolulu, HI 96826
Phone: (808) 955-1544 Fax: (808) 955-5474

***Please initial one**:

_____ 1. Only send records generated by this facility.

_____ 2. Please send the following:

- 2 most recent Progress Notes
- Most recent Labs, Radiology Report and/or X-ray

_____ 3. Only some portion of records maintained at this facility (specify below):

_____

_____ 4. Send all medical records at this facility including those provided by other offices.

---

*Should my medical record contain any information pertaining to alcohol and/or drug abuse, psychiatric evaluation, treatments and results, HIV tests and results, infectious diseases, including Acquired Immune Deficiency Syndrome (AIDS), I, by **initialing** the following:*

Consent _____ Do not Consent_____ to the release of medical information to the requesting party.

I hereby authorize disclosure of health information for the above named patient. This authorization is valid for one year from the date of signature. I understand that I may cancel this request with written notification, but that it will not affect any information released prior to notification of cancellation.

Patient/Parent/Legal Guardian Signature: _____ Date ____/____/____

Relationship to patient: _____