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

CONSENT TO RELEASE MEDICAL INFORMATION (Outgoing Information)

Patient Name____ Date of Birth ____/____/___

Person/Facility to **Receive** Records: ____

Address:____

Phone number:___________________________ Fax number: ___________________________

Please initial one:

______ 1. Only send records generated by this facility.

______ 2. Send all medical records at this facility, including those provided by other offices. Records previously obtained from other providers could contain information that may be sensitive to you, and this office may not have thoroughly read these records. We do not know if the records contain sensitive information, and we have no way of knowing whether the other provider released a complete copy of the record. However, by checking this box, you are authorizing us to release all information.

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

____

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. I hereby release Curtis Takemoto-Gentile, MD Inc. and its affiliated physicians from all liability and all claims of any nature whatsoever pertaining to disclosure of information, or of any professional opinions, findings, or recommendations as contained in the medical records.

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

Relationship to patient: ____