Aloha Dermatology & Laser Center - Micki Ly, MD **rev 9/23/2011**
Po Box 668 Pu`unene, HI 96784
Ph: (808) 877-6526 Fax: (808) 877-7033

MEDICAL RECORDS RELEASE FORM

Name: _____ **Birthdate:** _____ **Phone:** _____

I hereby authorize Dr. _____ to disclose my health information, including copies of medical records to:

- Any health insurance plan or company that provides coverage for me for the purpose of payment of charges.
- Any insurance company that provides liability insurance coverage for my physician for the purpose of evaluating the treatment or health care rendered to me.
- To Dr. _____ Phone: _____ Fax: _____

This authorization shall cover the period of time from:

[_] My first visit to my last visit **OR** [_] From: _____ (date) to _____ (date)

I understand that I can revoke this authorization at any time. This authorization shall end two years after the day of my last visit. I also understand that this authorization may allow the recipient of my health information to pass it onto others, so it may no longer be protected under federal law.

PUPOSE OF DISCLOSURE (check all that apply):

[_] Changing Physician _____ (doctor)
[_] School _____
[_] Insurance _____
[_] Worker's Compensation
[_] Continuing Health Care _____ (appointment date)
[_] Legal Purposes
[_] Consultation/Second Opinion
[_] Other (please specify) _____
_____

Signed: _____ **Date:** _____

Printed Name: _____

** Personal request for records fee: $16.25 per chart request plus records research fee. After the first 20 pages, an additional charge of $0.49 per page will be added.* ***Payment of $16.25 is due at time of request.*** *Records cannot be copied until receipt of the prepayment. Postage is an additional charge. Please make checks payable to* Micki Ly, MD.
P.O Box 668 Pu`unene, HI 96784

Any request for records can take up to 7 working days after receipt of authorization and/or prepayment.