RELEASE FORM OF HEALTH RECORDS
(Rev 06 02 2010)

Micki Ly, MD – Dermatologist
89 Hookele St. Suite 101
Kahului, HI. 96732
PH: (808) 877-6526 Fax: (808) 877-7033

I, ___________________________, hereby authorize Dr. ___________ to disclose my health information,
(Name of patient)
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 Dr. ____________ for the purpose of evaluating the treatment rendered to me.
For the purposes of:

____

____.

This authorization shall cover the period of time from my first visit to my last visit or from _______________ To _______________.
I understand that I can revoke this authorization at any time.
This authorization shall end two years after the day of my last visit.

PUPOSE OF DISCLOSURE (check all that apply):

[ ] Changing Physician [ ] Continuing Health Care, appointment date: __________________________.

[ ] School [ ] Insurance [ ] Legal [ ] Workers Compensation [ ] Consultation/Second Opinion
[ ] Other (specify): ____.

Signed _______________________________________
(Name of patient)
Date ________________

** Personal request for records fee: $15.60 plus tax totaling $16.25 per chart request, for the first 20 pgs, and $0.49 per page there after.* ***<u>$16.25 is an upfront payment</u>*** *plus records research fee of $20.00. Records cannot be copied until receipt of the prepayment. Postage is an additional charge. Please make checks payable to:*

Micki Ly, MD – Dermatologist
P.O Box 668
Puunene, HI 96784-0668

Any request for records will take 5 to 7 working days after the receipt of authorization and / or prepayment.