75-367 Hualalai Rd, Ste. A/B
Kailua-Kona, HI 96740, USA
1-844-900-SKIN (7546)
www.islandaestheticshi.com

Patient Authorization for Release of Protected Health Information to Island Aesthetics

By signing this authorization, I, _____ authorize
(Patient or Legal Representative)

_____
(Medical Facility) (Doctor/Provider's Name)

_____
(Address) (City, State, Zip Code)

_____
(Phone Number) (Fax Number)

to release certain protected health information (PHI) to Island Aesthetics.

This authorization permits the practice named above to use or disclose to Island Aesthetics the information designated below (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.).

[ ] Entire Medical Records [ ] Visit Notes [ ] Pathology Reports [ ] Lab/Test Results
[ ] Other (please list):
_____

_____

_____

_____

This authorization will expire on _____
(Expiration Date or Defined Event)

_____ _____
Signature of Patient or Legal Representative Relationship to Patient

_____ _____
Date Relationship to Patient

_____ _____
Patient Name Date of Birth

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