Jenny Horita Welham, MD
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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Name of Patient _____ Date of Birth _____

Reports to be Disclosed

___ History and Physical Exam
___ Consultation Report
___ Progress Notes
___ Radiology Reports
___ Laboratory/Pathology Reports
___ **Immunization Record**
___ **Growth Chart**
___ Billing Claim Forms
___ Operative Reports
___ Other
___ All Medical Records

Records Release From

Name of Doctor _____ Phone _____

Address _____ Fax _____

_____

_____

Records Released To

Jenny Welham MD LLC

1401 S. Beretania St. Ste. 370 Honolulu,
Hawaii 96814

Authorization

I authorize the third party named in the above section to disclose the protected health information about myself (or the patient) as described above. I understand:

1. This authorization expires 180 days from the date of my signature unless I specify otherwise.
   Expiration _____
2. I may revoke this authorization at any time by notifying Jenny Welham MD LLC in writing. If I revoke the authorization, I understand that it will have no effect on actions Jenny Welham MD LLC took in good faith before receiving the revocation.
3. The information released may contain information related to AIDS or HIV infection drug or alcohol abuse behavioral health or psychiatric care, except for psychotherapy notes.
4. Jenny Welham MD LLC may not withhold treatment or payment based on my completion of this form.
5. Jenny Welham MD LLC reserves the right to verify my identity or guardianship.

Signature _____ Date _____

Printed Name _____

Relationship to Patient _____