



Medical Records Release Form

By signing this form, I authorize Clear Medical Clinic to **RELEASE** confidential health information about me, by sending a copy of my medical records, or a summary or narrative of my protected health information to the physician/person/facility/entity listed below.

Patient name: _____ Date of Birth: _____

The information to be released is as follows:

Initial next to each selection to also include:

_____ Mental Health Information

_____ Genetic Testing Information

_____ HIV/AIDS Information

_____ Substance Abuse
Diagnosis/Treatment

Send my protected health information **TO** the following physician/person/facility/entity:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Signature of Patient or Personal Representative

Date

Printed name

Description of Personal Representative

Clear Medical Clinic

Address: P.O Box 1887, Koloa, HI 96756

Fax: (808) 204-1876

Phone: (808) 427-2250

Email: drkrebs@clearmedicalclinic.com