Authorization for Release of Protected Health Information

Frank R. Baum, M.D., Inc.
200 Kalepa Place, Kahului, HI 96732
Phone: 808-871-7116 Fax: 808-877-4134

Patient Name: **Date of Birth:**

I hereby authorize:

☐Frank R. Baum, M.D., Inc.

☐Other Facility/Provider (Include name, address, phone, and fax):

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To disclose the following health care information:

☐All of my child's health information

☐My child's health information relating to the following treatment or condition:

____

☐My child's health information for the date(s): ____________________________

☐Other (Please specify): ____

Release to:

☐Frank R. Baum, M.D., Inc.

☐Other Facility/Provider/Individual (Include name, address, phone, and fax if applicable):

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Record Format:

☐Paper ☐CD ☐email: ____

☐Fax: ____________________________

☐Other: ____

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Duration: _______________________ (Unless a different date is specified, this authorization will remain in effect for one year from date of signature)

Signature of Responsible Party: ____

Printed Name: ____

Relationship to Patient: _________________________________

Today's Date: _________________________

Frank R. Baum, M.D., Inc. will release only one personal copy of medical records at no charge with this signed consent. There will be a $25 fee charged for each subsequent personal copy requested.