OLAKINO HEALTH & WELLNESS LLC
PRACTICE ADDRESS: 75-5699 KOPIKO ST, STE A5 KAILUA KONA, HI 96740
CORRESPONDENCE ADDRESS: PO BOX 286 HOLUALOA, HI 96725

# Release of Medical Information

Patient's Full Name: _____
Patient's Date of Birth: _____

Complete Name, Address, Phone, Fax of Healthcare Provider, Hospital, or other Facility you would like us to release records to:
Facility Name: _____
Healthcare Provider Name: _____
Mailing Address: _____
_____
Phone Number: _____
Fax Number: _____

Permission or Limitations to release sensitive information:
By INITIALING below, I understand and allow records to be sent that may have information about:
____ My mental health
____ A disease I may have that others could get from me, like HIV/AIDS
____ Genetic records
____ Drug and alcohol records

By INITIALING below, I understand that:
____ I do not have to share these records
____ If I want to take away the permission for OLAKINO HEALTH & WELLNESS LLC to release these records, I may need to talk to my HCP or a staff person and sign a paper.

By signing below, I give my permission for OLAKINO HEALTH & WELLNESS LLC to release my medical records to the above entity so that my healthcare provider can better understand my condition and provide care for me.

_____ _____ _____
Signature of Patient, Guardian, or DPOA Initials Date Signed

_____
Printed Name & DOB of Guardian, DPOA (if applicable)