

RECORDS RELEASE AUTHORIZATION



JOHN C. FERGUSON, M.D.
677 ALA MOANA BLVD., SUITE 1011
HONOLULU, HI 96813
(808) 521-1999 FAX (808) 599-2972

Date: _____

Please release my medical records to:

The complete history records in your possession concerning my illness and/or treatment (or my child's illness and/or treatment, in the case of a minor) during the period from _____ to _____.

The operative report, for (type) _____ surgery.

Only the following portion of my records _____

My name at that time was: _____
(Please Print)

My name now is: _____
(Please Print)

Signature: _____

S.S. #: _____ **Date Of Birth:** _____

