Hawaii Women's Healthcare
Comprehensive Care in Obstetrics and Gynecology

Cheryl Lynn T. Rudy, M.D.
Cheryl L. Leialoha, M.D.
Angel M. Willey, M.D.
Erin C. Gertz, M.D.

Request for Medical Records

This authorization is valid for six (6) months from the date of signing, unless revoked in writing by the patient or authorized representative.

Physician's Name	
Address:	
Phone: ( )	Fax: ( )

I hereby request to release my medical records pertaining to _____

including any HIV/Lab results, Psychiatric information, or any substance and/or alcohol abuse.

Last Name:	
First Name:	
Maiden Name:	
Birth Date:	

To be released to:

☐ Dr. Cheryl Lynn T. Rudy, M.D.
☐ Dr. Cheryl L. Leialoha, M.D.
☐ Dr. Angel M. Willey, M.D.
☐ Dr. Erin C. Gertz, M.D.
☐ Dr. _____, Phone: _____, Fax: _____
☐ Self

At ☐ 1319 Punahou Street, Suite 760, Honolulu, Fax Number:(808)947-5805

_____ _____
Signature of Patient or Authorized Representative Date

If signed by other than the patient, please print name and indicate relationship to patient.

_____ _____
Print Name of Patient or Authorized Representative Relationship