

1063 Lower Main Street,
Suite C212
Wailuku, Maui, Hawaii 96793
www.RehabDrChester.com

JEFFREY H. CHESTER, DO

Phone 808.249.8887
Fax 808.249.8889
RehabDrChester@hotmail.com

Board Certified
By the American Board of Physical Medicine and Rehabilitation
Physiatry/Pain Management/Electrodiagnostic Medicine/EMG/Osteopathic Manual Medicine

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, authorize
Patient's Name Birth date Social Security Number

JEFFREY H. CHESTER, DO OR Name of person/organization authorized to release information
to Jeffrey H. Chester, DO

Print the name of person or organization

Street Address

City

State

Zip Code

To release the following medical records / information:

Release information to: _____

Send by mail

Address: _____

Send by fax to: _____

City/State/Zip: _____

I will pick up on: _____

Release of information is for the purpose of (*check one*): Continued care Other: _____

Initial one of the following:

_____ I **consent** to the release of any information pertaining to alcohol abuse, drug abuse, psychiatric condition,
initial any condition related to sexually transmitted disease and/or HIV (Human Immunodeficiency Virus) and
AIDS (Acquired Immune Deficiency Syndrome).

_____ I **do not consent** to the release of any information pertaining to alcohol abuse, drug abuse, psychiatric
initial condition, any condition related to sexually transmitted disease and/or HIV (Human Immunodeficiency
Virus) and AIDS (Acquired Immune Deficiency Syndrome).

- 1) This consent shall be valid for six (6) months from the date of the signing, unless revoked.
- 2) My permission is extended only for the purpose stated on this authorization.
- 3) If applicable, I understand that I will be responsible for any charges incurred for this service. _____
initial

Signature of patient or patient's guardian

Date

Address

Phone number