

# MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize and request you release a complete copy of my medical  
Records to:

Thomas Weiner MD  
Family Medicine  
73 Puuhonu, STE 101, Hilo, HI 96720  
Phone: 808-808-7780  
Fax: 808-666-9356 or 808 809 7101

**Name of Patient:**

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**Address of Patient:**

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**Signature of Patient or Patient's designated representative:**

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**Patient Representative name:**

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**Date:**

**Name, Address, Phone and Fax of Physician from whom you are requesting records:**

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