FC Adm 1/19/16

## MEDICAL RECORD RELEASE FORM

Date:	_
To Whom It May Concern:	
Re:(Child's Birthname and Birthdate)	
(Cinia s Birtimanie and Birtinate)	
I authorize release of:	
(1) my Medical Records regarding the birth of the above-named child; and	
(2) the medical information given in the "Medical Information Form" pertaining to me.	
Pursuant to section 578-14.5 of the Hawai'i Revised Statutes, the medical records and information	n
re for the purpose of perpetuation of medical information on natural parents of the above-name	d
hild, and are to be released to or for the benefit of the above-named child.	
Print Name of Natural Parent:	
Signature of Natural Parent:	
Print using black ink or use typewriter)	

In accordance with the Americans with Disabilities Act, as amended, and other applicable state and federal laws, if you require accommodation for a disability, please contact the ADA Coordinator at the First Circuit Family Court office by telephone at 954-8200, fax 954-8308, or via email at adarequest@courts.hawaii.gov at least ten (10) days prior to your hearing or appointment date.

Please call the Family Court Service Center at 954-8290 if you have any questions about forms or procedures.

Medical Record Release Form