State Department of Health
Office of Health Status Monitoring

MEDICAL RECORD RELEASE FORM

Date: ____________________

To Whom It May Concern:

Re: ____
(Child's Birthname and Birthdate)

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 are for the purpose of perpetuation of medical information on natural parents of the above-named child, 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.*

Section 508 Certified