Hawaii Women's Healthcare
Comprehensive Care in Obstetrics and Gynecology

Cheryl Leialoha M.D.
Cheryl Lynn T. Rudy, M.D.
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Andrea Wieland, APRN

# 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.**

| | |
|---|---|
| Physicians 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.
(Initials)

| | |
|---|---|
| Last Name: | |
| First Name: | |
| Maiden Name: | |
| Date of Birth: | |

**To be released to:**

- ☐ Cheryl L. Leialoha, M.D.
- ☐ Cheryl Lynn T. Rudy, M.D.
- ☐ Erin C. Gertz, M.D.
- ☐ Laura Spector, D.O.
- ☐ Saki Onda, M.D.
- ☐ Jennifer Griesel, M.D.
- ☐ Andrea Wieland, APRN

- ☐ Dr. _____ Phone: _____ Fax: _____
- ☐ Self
- ☐ 1319 Punahou Street, Suite 760, Honolulu, Hawaii 96826, Fax number: 808-947-5805

**For the purpose of:**

- ☐ At the Request of the individual
- ☐ Legal Purposes
- ☐ Insurance
- ☐ School
- ☐ Continuing Care/Treatment
- ☐ Transferring Care to another OBGYN/Midwife
- ☐ Other: _____

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Print Name of Patient or Authorized Representative Relationship