Hawaii Women's Healthcare
Comprehensive Care in Obstetrics and Gynecology

Cheryl Lynn T. Rudy, M.D.
Cheryl L. Leialoha, M.D.
Erin C. Gertz, M.D.
Laura A. Spector, D.O.
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.**

| | |
|---|---|
| Physician's 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.

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

**To be released to:**

☐ Dr. Cheryl Lynn T. Rudy, M.D.
☐ Dr. Cheryl L. Leialoha, M.D.
☐ Dr. Erin C. Gertz, M.D.
☐ Dr. Laura A. Spector, D.O.
☐ Andrea Wieland, APRN

☐ Dr. _____, Phone: _____, Fax: _____
☐ Self

At ☐ 1319 Punahou Street, Suite 760, Honolulu, 96826. Fax Number: (808)947-5805

_____ _____
Signature of Patient or Authorized Representative Date

If signed by other than the patient, please print name and indicate relationship to patient.

_____ _____
Print Name of Patient or Authorized Representative Relationship