Maui
PACIFIC
CANCER INSTITUTE

227 Mahalani Street
Wailuku, HI 96793
Tel (808) 249-1600
Fax (808) 249-1651

AUTHORIZATION FOR RELEASE OF INFORMATION

TO: _____

_____

_____

_____

You are hereby authorized to release requested information necessary for the continuation of my medical care to Pacific Cancer Institute, LLC.

Patient Name:_____
(If records are under a different name, please indicate)

Address:_____

_____

_____

Phone Number:_____

Date of Birth:_____ SSN #:_____

_____
Patient's signature Date

_____
Relationship if signed by other than Patient

____Pathology Report	____Prior Treatment Records
____Medical Records	____Prior Completion Note
____X-Rays	____Prior Simulation/Port Films
____CT Scans/MRI	____Chemotherapy Records

Other _____