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JEFFREY H. CHESTER, DO
Board Certified
By the American Board of Physical Medicine and Rehabilitation
By the American Board of Addiction Medicine
Physiatry/Pain Management/Electrodiagnostic Medicine/EMG/Osteopathic Manual Medicine/Addiction Medicine

Phone 808.249.8887
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:_____ Date of Birth: _____ SS# _____

Mailing Address:_____

_____

I authorize the medical office of Dr. Jeffrey H. Chester, DO to release my medical records to me for my records. I understand that my permission is only for the records I request below. I understand there is an administrative fee for this service, which is thirty cents ($0.30) per page, plus 4.166% Hawaii State tax. The administrative fee covers the photocopying, supplies and labor. Postage is an additional charge if I request the copies mailed to me. Furthermore, I understand that payment is required prior to the photocopying. *Note: It make take up to ten (10) business days for your request to be processed.*

Medical Records Requested:_____

_____

I _____ consent _____ do not consent to the release of any information pertaining to alcohol abuse, drug abuse, psychiatric condition, any condition related to sexually transmitted disease and/or HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome).

Send records ❒ By Mail ❒ Call for Pick-up ❒ Fax:_____

_____ = Estimated Number Pages to be copied

$_____ = Estimated Cost ($0.30 per page + 4.166% tax)

$_____ = Estimated Postage (1-9 pages=$2.00; 10-20 pages=$5.00; 21+ pages = $15.00)

$_____ = Total Pre-Payment Due by cash, credit card, debit card or money order (NO CHECKS)

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed Name of Patient or Legal Guardian Phone Number

FOR OFFICE USE:

Pre-Payment $_____ Date of Prepayment:_____ ❒ cash ❒ debit ❒ credit ❒ money order

Actual Number Copies = _____ x $0.30/page = $_____ plus 4.166% tax = $_____

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Photocopying Cost + Postage = $_____

Patient to be refunded $_____ Date of Refund: _____

Balance Due $_____ Date Balance Paid: ❒ cash ❒ debit ❒ credit card