Dr. Kevin Fujikawa
4944 Sunrise Blvd Suite H
Fair Oaks, CA 95628
Phone: (916) 966-8158 Fax: (916) 966-8118
Email: Office@drfujikawa.com

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Date of Birth: _____
Home Address: _____
City: _____ State:_____ ZIP:_____
Telephone Number: _____

SEND MEDICAL RECORDS
☐TO ☐FROM
Dr. Kevin Fujikawa
4944 Sunrise Blvd Suite H
Fair Oaks, CA 95628
Phone: (916) 966-8158 Fax: (916) 966-8118
Email: Office@drfujikawa.com

SEND MEDICAL RECORD
☐TO ☐FROM

Physician/Clinic: _____
Address: _____
Telephone: _____ Fax:_____

INFORMATION REQUESTED:

☐ALL RECORDS
☐RECORDS FOR DATES _____-_____
☐HIV or MENTAL HEALTH

This authorization is valid for 90 days from the date set forth below opposite my signature and may be revoked at any time in written form prior to the expiration of such 90 day period. Revocation of this authorization shall not affect releases made prior to the revocation.
I understand that authorizing the disclosure of my protected health information is voluntary and that I need not sign this authorization in order to assure medical treatment. I further understand that the disclosure of this information carries with it the potential for unauthorized re-disclosure and the information may no longer be protected by federal confidentiality rules.
I certify that I have the authority to approve this requested release and to sign this authorization.

_____ Date:_____
Patient Signature (or legal representative)

PLEASE ALLOW 7-10 BUSINESS DAYS FOR DELIVERY OF CHART. THERE IS ALSO A MINIMUM FEE OF $25.00 PER CHART REQUESTED.