

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

In compliance with Title 19, Chapter 323C Hawaii Revised Statutes
I, authorize Portner Orthopedic
Rehabilitation, Inc. Bernard M. Portner, M.D., Stephen M. Scheper, D.O., and
Neelesh B. Fernandes M.D., to disclose / fax my health information, including
copies of medical records relating to the treatment of my injuries and / or
conditions which have results from or are directly related to a motor vehicle /
private / or work related accident on _____ (date
of accident) for the purpose of evaluation the treatment rendered to me, payment of
charges, or to approve the following treatment plans submitted by Portner
Orthopedic Rehabilitation, Inc.

This authorization shall cover the period of time from my first visit to my last
visit.

I understand that I can revoke this authorization at any time.
This authorization shall end two (2) years after the date of my last visit.
I understand that I can obtain a copy of Portner Orthopedic Rehabilitation, Inc. a
notice regarding confidentiality of medical records upon request.

Signature _____

Date Signed _____

Portner Orthopedic Rehabilitation, Inc.
615 Piikoi St. Suite #1210
Honolulu, Hawaii 96814
phone: (808) 596-7300 fax: (808) 596-7305

Signature _____

(Print) Name of Patient _____

Social Security Number _____

Date _____