407 Uluniu Street Suite 312
Kailua HI 96734
808-262-0544
Fax-808-262-3744

1401 S. Beretania Street Suite 250
Honolulu HI 96817
(808) 545-2800
Fax-808-262-3744

Patient – Partner Release of Medical Information Consent

I hereby authorize:

Advanced Reproductive Medicine and Gynecology of Hawaii, Inc.
&
Fertility Institute of Hawaii

☐ John Frattarelli, M.D.

☐ Anatte Karmon, M.D.

☐ LeighAnn Frattarelli, M.D.

☐ Sloane Berger-Chen, M.D.

To release my medical records to my spouse/partner for the purpose of sharing information as it relates to my treatment plan. His/her name and contact information is as follows:

Name:____

Address:____

Phone Number:_________________________E-mail:__________________________________

Description of information: Disclosure is authorized for any and all medical information including physicians' notes, operative reports, laboratory results, pathology results, and radiology reports unless otherwise specified.

Duration: This authorization is valid for one year from the date of the signing unless revoked in writing by the undersigned within one year.

Patient Name:______________________________ Date of Birth:___________________________

Phone number:______________________________

________________________________ _____________________

Patient Signature Date