

MEDICAL RECORD RELEASE FORM

Date _____

To Whom It May Concern:

Re: _____
Birth Name of Child and Birth Date

I authorize release of the medical information given in the attached "Medical Information Form" pertaining to me. The information is prepared under Section 578-14.5, Hawaii Revised Statutes, for the purpose of perpetuating medical information on natural parents of adopted minor child, and is to be released to or for the benefit of the adopted child.

Name of Natural Father: _____
Print Full Name

Signature: _____