Wee Care Pediatrics
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Authorization for Disclosure of Health Information

Records from:
Clinic name: _____
Address: _____
City, State, Zip _____
Phone:_____
Fax: _____
Email: _____

Released To:
Name:_____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
Email:_____

Child's Name:_____ Date of Birth:_____
Home Address:_____
City, State, Zip:_____
Phone:_____ Secondary Phone:_____
Contact Person or Parent:_____

Information to be Disclosed (check all that apply):

☐ **ALL RECORDS**
☐ Discharge Summary __ ER Record
☐ Progress Notes __ Treatment Plans
☐ Discharge Instructions __ X-Ray reports
☐ Medications __ History & Physical
☐ Lab Reports
☐ Doctor's Orders
☐ HIV testing/results __ Consultations
☐ ECG/EEG Reports __Nurse Notes
☐ Operative Reports __Therapy Notes

Purpose or Need for the Disclosure: ☐ Continued Medical Care ☐ Change of Insurance ☐ Legal Use ☐ Patient's Own Use ☐ Change of Physician ☐ Moved

IF MORE THAN 30 PAGES TOTAL, RECORDS MUST BE MAILED (OR PUT ON CD IN PDF FORMAT) OR EMAILED TO WEECARERECORDS@HUSHMAIL.COM

Please allow 30 days for delivery of records by mail.

My refusal to sign this form will not adversely affect my ability to receive healthcare services, reimbursement for services, and enrollment in a health plan or my eligibility for health benefits. However, information will NOT be released to the above indicated recipient without my signature on this form. I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected my Federal Law. I have the right to revoke this authorization by written notice to the Healthcare provider listed above. I understand that the actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires on _____ or upon the following event: _____

I understand that the information in my medical records may include information relating to treatment of drug or alcohol abuse, mental health, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

FEES: I understand and agree that there may be costs associated with this request in compliance with state copying laws. _____ _____

(Signature of Patient, Patients' Parent or Personal Representative)* *Date of signature*