Patient Authorization to Transfer Medical Records

or Disclose Other Protected Health Information to Wee Care Pediatrics

By signing this authorization, I authorize release of medical records of the following:

____ Whose DOB is__________________

Name of Patient (Month/Day/Year)

From:

Office Name: ____

Doctor's Name: ____

Address: ____

Phone#: (________)_______________________________

Fax#: (________)_______________________________

To:

Wee Care Pediatrics
1440 S. Country Club Dr. Suite 21
Mesa, AZ 85210
Phone 480-890-2273, Fax 480-890-2201

Please transfer and/or disclose the following information:

☐ All Medical records, files, charts, reports and other associated health information

OR

☐ The following specific Protected Health Information (PHI) (check all that apply)

__ Medical Records & Charts __Immunizations Records __ X-Rays or Diagnostics

__ Lab Results __ Others (Please Specify) ______________________________

I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand I do not have to sign this authorization in order to get health care benefits. I understand that I have the right to revoke this authorization at any time in writing, except to the extent that the medical provider named above or Wee Care Pediatrics has acted in reliance upon the authorization.

Relationship to Patient:
Name of Patient/Parent/Legal Guardian:
Address:
Phone Number:
Signature:
Date:

Scan: Medinotes\Patient View\Patient Name\Multimedia\PMH\(Type in: Medical Records), To be scanned ONLY with previous Medical Records