Wee Care Pediatrics
Where Compassion, Caring and Dedication Come First

Authorization to Release and Disclose Protected Health Information

Patient Name: _____ DOB: _____

I hereby authorize the release and discloser of the specified information described below.

Check the information to be used or disclosed:

____ Complete Medical Record ____ Labs or X-ray's
____ Immunization Record ____ Other: _____

(Genetic testing or other "sensitive" matter will not be included unless specifically authorized by parent or legal guardian NRS.629.171)

Reason for Request:

____ Provider Request ____ Parental/Personal Request
____ Transfer of Medical Care ____ Other: _____

Transfer Records To / From (If records are being released FROM Wee Care Pediatrics, circle FROM)
Name of Physician or Practice: Wee Care Pediatrics

Address: 4785 S. Durango Dr. Ste 101 City: Las Vegas State: NV Zip: 89147

Phone: (702) 889-8444 Fax: (702) 933-4282 (Medical Records Fax)

***** DO NOT FAX MORE THAN 20 PGS PLEASE MAIL, ENSURE CD'S ARE B&W AND PDF FORMAT*****

Transfer Records From / To (If records are being released TO another facility, circle TO)

Name of Physician or Practice: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I understand: that once the Protected Health Information (PHI) is disclosed, it may no longer be protected by federal privacy law if received by a non-health care facility; I may terminate this authorization at any time by submitting a written revocation to the above provider and address; I have the right to receive a copy of this authorization and any records obtained with its use; I have the right to request and inspect my medical records or obtain copies of my health records by contacting the Privacy Officer at any time; Wee Care Pediatrics requires a release form each time records are requested to avoid any overuse or unauthorized request to my child's medical records due to changes in my family dynamics.

* PLEASE SEND COPY OF PICTURE ID *

_____/_____
Signature of Parent or Legal Guardian Date

_____/_____
Printed Name Relationship to Patient

THERE WILL BE A CHARGE OF $0.60 PER PAGE FOR PRINTING MEDICAL RECORDS (NRS.629.061) RECORDS OVER 20 - 25+ PAGES WILL BE SUPPLIED ON DISK IN PDF FORMAT- FEE $12.00-$15.00. $3.00 CHARGE FOR REPRINT OF IMMUNIZATION RECORDS. PLEASE ALLOW UP TO 30 DAYS FOR PROCESSING OF FULL OR PARTIAL RECORDS. WE WILL MAKE EVERY ATTEMPT WITHIN THE LIMITATIONS OF THE LAW, TO ACCOMMODATE YOUR REQUEST.