WEE PEDIATRICS, INC.
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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

(Medical Record's Request)

Patient Name: _____ DOB: _____/_____/_____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

I hereby authorize Wee Pediatrics, Inc., Lyla C. Prather, M.D. to: **Please mark only one**

_____Obtain Records from Prior Physician ____ Release Records to: **Please complete the information requested below completely**

Name of Physician, Hospital, Company, or Person Authorized to release/receive medical records:

Name: _____ Address: _____

City_____ State: _____ Zip Code: _____ Fax: _____

Purpose of Release	**Type of Records Requested**
☐ Continuing care by another Physician	☐ All Medical Records(This **does not** include records from other physician offices)
☐ Moving	☐ Physician Notes only
☐ Physical	☐ Lab Results ☐ X-ray Results
☐ Personal Use	☐ Immunizations only
☐ Other Please Specify	☐ Other Please Specify

I authorize the release of Photocopies of the following records and/or x-ray films in the possession of Wee Pediatrics, Inc. LYLA C. PRATHER, M.D., its employees, and/or agents. For the purpose hereof, "Medical Records" and "X-ray Films" shall include all sensitive information: I understand that the information in my record may include information relating to:

1. CONFIDENTIAL (HIV) - OR ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) RELATED INFORMATION
2. CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION
3. CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION
4. CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION
5. CONFIDENTIAL GENETIC TESTING INFORMATION

I have given my consent freely, voluntarily, and without concern. I understand that a photocopy of the authorization is to be considered acceptable in lieu of the original. I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

_____ _____ _____
Patient/Legally Authorized Representative Relationship to Patient Date

_____ _____ _____
Signature of Office Witness Printed Name Date