WEE PEDIATRICS, INC.
KAREN ORTIZ, M.D. PEDIATRICS
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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 Karen Ortiz, 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: ____________ Phone: ____________

Purpose of Release	**Type of Records Requested**	
☐ Continuing care by another Physician	☐ All Medical Records(This **does not** include records from other offices)	
☐ Moving	☐ Physician Notes only	
☐ School/Daycare	☐ Lab Results	☐ X-ray Results
☐ Personal Use	☐ Immunizations only	☐ Sports Physical
☐ 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., Karen Ortiz, 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.

______________________ ______________________ ____________
Parent/Legally Authorized Representative | Relationship to Patient | Date

______________________ ______________________ ____________
Signature of Office Witness | Printed Name | Date