

**WEE CARE PEDIATRICS GROUP PLLC-MEDICAL RECORDS**  
**5187 SUITE 11, U.S. ROUTE 60**  
**HUNTINGTON, WV 25702**  
**PHONE 304-399-5437**  
**AUTHORIZATION TO USE AND DISCLOSE MEDICAL INFORMATION**  
**PLEASE DO NOT FAX RECORDS**

**Patient Name:** \_\_\_\_\_ **Phone Number** \_\_\_\_\_  
**SSN:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

1. I authorize Wee Care Pediatrics Group PLLC to use and disclose the above individual's medical information as described below \_\_\_\_\_ to the following individual/organization, \_\_\_\_\_ from the following individual/organization.

**Previous Dr. /Clinic Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Telephone Number:** \_\_\_\_\_  
**For the purpose of:** Transferring to Wee Care Pediatrics Group PLLC

2. The type and amount of information to be used or disclosed is as follows (include month and year when possible):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ **Please also include patient's shot record and growth curves.**

3. I understand that my medical information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the department. I understand the revocation will not apply to information that has already been released in response to the authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will automatically expire within 90 days of the date of this request.

5. I understand that authorizing the use and disclosure of this medical information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about disclosures of my medical information, I can contact the appropriate department.

\_\_\_\_\_  
**Signature of Patient or Legal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**If Signed by Legal Representative, Relationship to Patient**

\_\_\_\_\_  
**Name of Witness (Please Print)**

\_\_\_\_\_  
**Signature**

**1<sup>st</sup> Attempt** \_\_\_\_\_ **2<sup>nd</sup> Attempt** \_\_\_\_\_ **3<sup>rd</sup> Attempt** \_\_\_\_\_ **4<sup>th</sup> Attempt** \_\_\_\_\_