REQUEST FOR RELEASE OF MEDICAL RECORDS

CURRENT INFORMATION

PATIENTS NAME (LAST, FIRST MIDDLE)	PATIENTS DATE OF BIRTH (MO/DAY/YR)
PHONE NUMBER	PARENT/GUARDIAN

RECORDS REQUESTED ARE TO BE RELEASED FROM:

FACILITY NAME/PROVIDER/PARENT/OTHER		
ADDRESS		
CITY	STATE	ZIP CODE
PHONE NUMBER		FAX NUMBER

RECORDS REQUESTED ARE TO BE RELEASED TO:

FACILITY NAME/PROVIDER/PARENT/OTHER WEE CARE PEDIATRICS		
ADDRESS 1580 WEST ANTELOPE DRIVE, SUITE 100		
CITY LAYTON	STATE UTAH	ZIP CODE 84041
PHONE NUMBER 801-773-8644		FAX NUMBER 801-773-9828 OR 801-927-1588

REASON FOR RELEASE (REQUIRED)

PLEASE SEND THE FOLLOWING INFORMATION:

____ COMPLETE RECORD ____ SPECIFIC DATE OF SERVICE ________________________

____ MOST RECENT PHYSICAL OR WELL CHECK ____ OTHER (SPECIFY): ________________________________

I hereby authorize the releasing facility to release information as indicated. The following releasing facility is hereby released from all legal liability that might arise from the release of the information requested. I understand that my records are protected and cannot be disclosed without my written permission, with the exception of information release pertaining to treatment, payment, or healthcare operations as specified by HIPPA or as required by law. I also understand that my consent for release is subject to my written revocation. Once "WeeCare Pediatrics" discloses my health information by my request, third parties cannot re-disclose this information. We recommend you keep a copy for your personal records for future use. A duplicate copy could incur charges of 25 cents to 25 dollars per child. This consent will remain in force for 30 days from the date signed in order to effectuate the purpose for which it was given. WE ARE UNABLE TO RELEASE OTHER DOCTOR'S OR FACILITIES MEDICAL RECORDS.

PARENT OR GUARDIAN SIGNATURE:	RELATIONSHIP TO PATIENT:		DATE:
CHECKED PICTURE ID:	☐ DRIVERS LICENSE	☐ MILITARY ID	☐ SSN (VERIFY LAST 4 DIGITS)
WITNESS (EMPLOYEE NAME)	DATE		

MEDICAL RECORDS

DOCUMENTATION LOCATION:	☐ SCANNED INTO CHART UNDER "RELEASE OF INFORMATION"
EMPLOYEE COMPLETING REQUEST:	DATE:

*AFTER COMPLETING PLACE INTO MEDICAL RECORDS BOX