Wee Care Pediatrics
Margot A. Crossley, D.O.
6965 Tutt Blvd, Ste #100
Colorado Springs, CO 80923
Phone: 719-266-5944 Fax 719-266-5947

Authorization for Disclosure of Health Information

I hereby authorize_____
(Name of Facility) *(Phone # of Facility)*
to release medical information for the records of:
Patient Name: _____
D.O.B._____/_____/_____
Street Address:_____
City State ZIP
Primary Phone #: _____Secondary Phone #: _____

Information to be Disclosed (check all that apply): __ Discharge Summary __ ER Record __ Progress Notes __ Treatment Plans __ Discharge Instructions __ X-Ray reports __Medications __ History & Physical __ Lab Reports __ Doctor's Orders __ HIV testing/results __ Consultations __ ECG/EEG Reports __Nurse Notes __ Operative Reports __Therapy Notes __ **ALL RECORDS**

Purpose or Need for the Disclosure: __ Continued Medical Care __ Change of Insurance __ Legal Use __ Patient's Own Use __ Change of Physician __ Moved

PLEASE MAIL RECORDS IF MORE THAN 30 PAGES TOTAL!

Please send Information to be Disclosed to:

Wee Care Pediatrics
6965 Tutt Blvd, Ste #100
Colorado Springs, CO 80923
Phone: 719-266-5944 Fax 719-266-5947

My refusal to sign this form will not adversely affect my ability to receive healthcare services, reimbursement for services, and enrollment in a health plan or my eligibility for health benefits. However, information will NOT be released to the above indicated recipient without my signature on this form. I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected my Federal Law. I have the right to revoke this authorization by written notice to the Healthcare provider listed above. I understand that the actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
This authorization expires on _____ or upon the following event: _____

I understand that the information in my medical records may include information relating to treatment of drug or alcohol abuse, mental health, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).
FEES: I understand and agree that there may be costs associated with this request in compliance with state copying laws. _____
(Signature of Patient, Patients' Parent or Personal Representative) Date of signature*