Wee Care Pediatrics
2709 Mackey Lane
Shreveport, La 71118

Authorization for Release of Medical Records

Patient Name:_____ DOB:_____

Address:_____ Phone Number: _____

_____

I, the undersigned, authorize/request the below names medical office/physician/hospital to release my medical records.

Name of physician/office/hospital: _____

Address;_____ Office phone number:_____

_____ Office fax number: _____

Please release my medical records to :

Wee Care Pediatrics
Hester Suh, MD
2709 Mackey Lane
Shreveport LA 71118
Phone (318) 505-7626 Fax: (318) 266-7976

My request for the particular release of medical records includes the following:

_____ All healthcare information INCLUDING information relating to HIV/AIDS, sexually transmitted illnesses, psychiatric disorders , and drug/alcohol abuse

_____ All healthcare information EXCLUDING information relating to HIV/AIDS, sexually transmitted illnesses, psychiatric disorders, and drug/alcohol abuse

The facility and its doctors are hereby released and discharged from any liability and the <u>undersigned will hold the facility and its doctors harmless for complying with this authorization.</u>

_____ _____
Signature of Patient or Authorized Representative Date

NOTICE TO PERSON OR AGENCY RECEIVING THIS INFORMATION: *This information has been disclosed to you from records whose confidentiality is protected. Statues and regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.*