TO OBTAIN A COPY OF MEDICAL RECORDS:

1. Complete the personal information at the top of the form for the patient health records being requested.
2. Patients must sign and date the bottom of the form where indicated.
    a. Patients age 12 and older must sign and date the form where indicated for the release of any sensitive information contained within the medical record request.
3. The parent or legal guardian of a patient under 18 years of age or disabled must also sign and date the bottom of the form where indicated (Not required if 7a is applicable).
4. Please note, if someone other than the patient, parent or legal guardian is signing this form, valid documents to support the Representative's authority to release/receive medical records must be provided.
5. Please contact WellNow at (716) 699-9032, Option 5, if you have any further questions regarding the completion of this form.

Completed and signed authorization forms should be sent to WellNow:

By Mail to:

For Illinois, Indiana, New York, and Pennsylvania Clinics

WellNow Urgent Care
P.O. Box 10459
Albany, NY 12201

For Ohio and Michigan Clinics

P.O. Box 10249
Albany, NY 12201

or by Email to:

medicalrecords@wellnow.com

or by Fax to:

(315) 410-5452

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Legal Name _____ **Date of Birth** _____

By signing this form, I am allowing WellNow Urgent Care located at, _____ to release my medical information concerning the above-named patient to the person or facility listed below.

_____

Name of Person and/or Institution who will receive information

_____

Complete Mailing Address/Street/P.O. Box City, State, Zip Code

_____

Telephone Number E-mail Address Fax Number

Check the information to be released:

☐ Clinic Visit(s): Dates of Service: _____

☐ Billing Information: Dates of Service: _____

☐ Lab Results: Dates of Service: _____

☐ X-Rays/Imaging: Dates of Service: _____

☐ Occupational/Employment Records: Dates of Service: _____

☐ Entire Medical Record

I specifically authorize WellNow Urgent Care to re-release external documents/records that have become a part of my permanent medical record. ☐ Yes ☐ No

Purpose of Disclosure: ☐ At the request of the individual ☐ Medical Care/Transferring Care

☐ Legal ☐ Insurance/Worker's Compensation

This authorization is voluntary. I have the right to cancel this authorization at any time by writing to the WellNow Urgent Care listed above. If this authorization is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions at any time by contacting the Manager of Patient AR – medicalrecords@wellnow.com. I have been offered a copy of this authorization.

WellNow Urgent Care does not require completion of this form as a condition of evaluation or treatment. I understand that the information may be released electronically, and may include information in the following categories unless I specifically deny the release

(Initial any category <u>NOT</u> to be released) **____Substance Use/Treatment ____Mental Health ____HIV-related information**

____Reproductive Health ____Sexually Transmitted Infections

This authorization will expire one year from the date of signature, unless cancelled by the patient/legal guardian sooner.

_____

Signature of Patient or Legal Guardian Printed Name Relationship if Not the Patient Date

WellNow Use ONLY:	
Information Released by	Date