Piedmont Urgent Care BY WellStreet

MEDICAL RECORDS RELEASE FORM

Patient Name					
Previous Name, if applicable					
Last 4 digits of SSN					
Address					
City		State		Zip	
Date of Birth					
Home Phone					
Work Phone					
Email address					

1. **Piedmont Urgent Care by WellStreet Healthcare Facility/Facilities:**

I authorize representatives from the following facility/facilities to disclose the health information as directed below:

Piedmont Urgent Care by WellStreet

2. **Receiving Party**

Please send my health information to:

Name					
Address					
City		State		Zip	
Phone					
Fax	Continuing patient care support only				

3. Description of Health Information To Be Disclosed:

☐	**Complete medical record**	**Visit Date**	

OR

☐ **Partial Medical Record (Please specify records below)**

☐	Electronic Continuity of Care/Electronic Abstract	**Visit Date**	
☐	Billing Records	**Visit Date**	
☐	History & physical	**Visit Date**	
☐	Office notes/Progress notes	**Visit Date**	
☐	Discharge summary	**Visit Date**	
☐	L ab results	**Visit Date**	
☐	X-rays	**Visit Date**	
☐	EKG reports	**Visit Date**	
☐	Itemized Bill	**Visit Date**	
☐	Other	**Visit Date**	

4. Purpose of Disclosure

❑ At my request

❑ Other: _____

5. Expiration of Authorization

Unless I request in writing otherwise, I understand that this authorization will expire on: _____.

(Insert expiration date or event). If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.

6. Right to Revoke Authorization

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department(s) of the Piedmont Urgent Care by WellStreet facility or facilities checked above. A list of addresses for the Medical Records Departments is contained in the Piedmont Urgent Care by WellStreet Healthcare, Inc. Notice of Privacy Practices. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

7. Re-disclosure

I understand that if my health information is disclosed to a party other than a health care provider, health plan or healthcare clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

8. Fees

I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees.

9. Refusal to Authorize Use and/or Disclosure

If I have been asked to sign this form in order to authorize the disclosure of my health information for purposes related to research, or for other reasons, I understand that Piedmont Urgent Care by WellStreet may decline to treat me if I refuse to sign this authorization only if: (1) the treatment would be related to a research project and this authorization is for the use or disclosure of my health information such research; or (2) the treatment would be for the sole purpose of creating health information for disclosure to a third party (such as a workers compensation examination).

10. Release and Waiver

If the health information that I have requested Piedmont Urgent Care by WellStreet to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), Immunodeficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), Venereal Disease, Tuberculosis, or Hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Piedmont Urgent Care by WellStreet, each of the Piedmont Urgent Care by WellStreet facilities checked above, and their officers, trustees, agents and employees from any and all liabilities, damages and claims, which might arise from the release of the health information authorized by me above.

Signature of Patient (or Patient's Representative) Date

_____ _____

Printed Name_____

Description of Authority to Act for Patient_____

Note: *a copy of this completed, signed and dated form must be provided to the patient and/or Patient's representative and a copy must be placed in the patient's medical record*