WellBe
SENIOR MEDICAL

Fax: 708-575-4466
medicalrecords@wellbe.com

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION (Void if Form is Modified)

SECTION 1: Patient Information (please print and complete ALL fields)

First Name _____ Last Name:_____

Date of Birth:

Address: _____City/State/ZIP:_____ Phone:

SECTION 2: Information Requested (please check all appropriate boxes)*****

Please indicate the specific type of information to be disclosed.

Charges may apply. Please contact us for details. Cash payments are not accepted.

☐ Progress Notes ☐ Medication List ☐ Labs ☐ Communications ☐ Billing

☐Orders ☐ Telephone Encounters ☐ Immunizations

Other: Optometry reports _____

*For the following dates of treatment: most recent visit notes most recent records for pt. _____

SECTION 3: I authorize release of the above patient records to:

Name of Individual/Organization: WellBe Senior Medical_____ Phone:_____

Address:_____ City/State/ZIP:_____ Fax:_____

***NOTICE ABOUT SENSITIVE INFORMATION, IN ACCORDANCE WITH 45 CFR § 171.204(a)(2): Electronic medical record systems are not designed to segment (1) Mental Health, (2) HIV/AIDS/STD, (3) Genetic Testing, or (4) Drug/Alcohol Abuse "sensitive information" from other information in your medical records. THEREFORE, THIS SENSITIVE INFORMATION WILL BE RELEASED TO THE INDIVIDUAL/ORGANIZATION NAMED IN SECTION 3 UPON YOU SIGNING THIS FORM.**

**** For minors ages 12-17, the minor's signature is required in Section 6 for the release of Mental Health Records.**

SECTION 4: Method of Delivery

Fax: (____)_____ ☐ U.S. Mail ☐ Email

Address:_____

SECTION 5: Purpose of Disclosure

Continuation of Care ☐ Personal Reasons ☐ Insurance ☐ Other: _____

☐ Legal *** (Will include Mental Health, HIV/AIDS/STD, Genetic Testing, and Drug/Alcohol Abuse information, if included in treatment dates requested; refer to Section 2 above)**

SECTION 6: Signature(s)

- I understand I have the right to revoke this authorization in writing at any time by sending revocation to medicalrecords@wellbe.com. The revocation will not apply if the disclosure has already acted in reliance on this authorization.
- I understand this authorization will expire in 90 days or upon the following specified date _____ or event _____.
- I understand information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by law.
- I understand I have the right to inspect/receive a copy of the information used/disclosed and receive a copy of this form.
- *** I understand that disclosure will include Mental Health, HIV/AIDS/STD, Genetic Testing, and Drug/Alcohol Abuse information (refer to Section 3 above).**
- I understand I have the right to refuse to sign this authorization, and treatment is not conditioned on this authorization, except disclosure necessary for payment of claims (excluding psychotherapy notes) or provision of healthcare solely for the purpose of creating PHI for disclosure to a third party (e.g. pre-employment or life insurance physicals).

I HEREBY ACKNOWLEDGE I HAVE READ AND FULLY UNDERSTAND THE STATEMENTS AND CONSENT TO THE RELEASE OF RECORDS.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

(Witness required unless continuation of care is marked in Section 5, or records are produced to the patient)

Representative Signature (for minors, etc.):_____ Relationship: _____ Date: _____