MEDICAL RECORDS RELEASE FORM

Due to the requirements of the Health Insurance Portability and Accountability Act (HIPAA), documentation is required each time medical records are requested for release. This form authorizes WellStreet Urgent Care, its physicians and/or representatives, to release your protected health information. By signing this form, you agree that WellStreet Urgent Care's physician(s), staff or representatives are not responsible for any and all action or adverse consequences as a result of releasing this sensitive information.

*This form will stay in effect for 30 days from the time you sign and date it. If you would like to revoke authorization prior to when those 30 days have expired, please notify a WellStreet Urgent Care representative.

Patient Name: ______________________ Date of Birth: ______________________

Name of Person Making Request: ______________________

Relationship to Patient: ☐ Self ☐ Parent/Guardian ☐ Referral Physician ☐ Attorney ☐ Other: __________

Person or Entity Records are Released To: CD SERVICES INC.

Address: 24027 Research Drive City, State, Zip: Farmington Hills, MI 48335

Phone Number: 248-476-1700 Fax Number: 248-476-6600

Reason for Request: ☐ Patient Care ☐ Insurance Payment ☐ Personal Injury Claim ☐ Health Care Liability Claim ☐ Personal Injury Claim ☐ Other: __________

Please list any information you would like excluded from your file when releasing your medical records: __________

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I acknowledge that WellStreet Urgent Care and any of its representatives cannot be held liable for any and all action or adverse consequences as a result of releasing these medical records. I understand that this authorization will expire in 30 days, unless WellStreet Urgent Care is notified otherwise by the patient or a legal representative.

Patient Signature: ______________________ Date: __________

Printed name of Patient Representative: ______________________

Signature of Patient Representative: ______________________ Date: __________