Authorization for William Wenokor, M.D. to Use or Disclose My Health Information

Name	SSN	DOB	Previous Name (aka)

I authorize that my protected information be obtained and disclosed between William Wenokor, M.D. and

_____
Name of Person/Agency/Organization/Physician/other

_____Fax_____ Phone_____
Address

Specific Information to be Released: (please choose one):

- ☐ As a patient, you are entitled to a complete copy of your medical records from our office for up to seven years. However, to streamline your continued care with the new provider, the initial assessment and the past year of clinical notes are the most relevant. By signing this release, you agree to the release of these limited records, knowing you or your provider can request a complete copy of your documents anytime.
- ☐ All my health information

The information identified above is necessary for: _____

Date or event upon which this authorization will expire: _____

- I understand that the medical information released by this authorization may include information concerning physical and mental illness, alcohol/drug abuse (information protected by Federal Law (42 CFR, Part 2), HIV/AIDS (information protected by Colorado Law (CRS 18-4-412)), previous medical history, criminal history, or educational records. I understand that this authorization for disclosure is voluntary and that I can refuse to sign this authorization.
- I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Dr. William Wenokor or the above-mentioned party based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I hereby release the above parties from liability that may result from furnishing this information.
- Once the office discloses health information, there is a potential for the information released to be redisclosed by the recipient and it may no longer be protected by the HIPAA Privacy Regulation.
- For disclosures other than for treatment, payment and healthcare operations purposes, treatment may not be conditioned on my agreement to sign an authorization (unless I am receiving care solely to create protected health information for disclosure to a third party).
- A photocopy or fax of this release is as effective as the original.

_____

Patient or legally authorized individual signature Printed name and relationship Date

_____
Witness