Christopher J Wenner MD, PA
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Authorization for Release of Medical Information

Patient	Name Date of Birth Address Phone Number City State Zip
Clinic/Hospital Send information to:	Name Address City State Zip
Clinic/Hospital Send information from:	Name Address City State Zip
Information to be Disclosed:	__History and Physical __Progress Notes __Discharge Summary __Outpatient information __Operative report __ All Records __Pathology Report __ Other _____ __Laboratory Report
Format of Information:	__Access to electronic medical record X Facsimile
Special Disclosure	__Chemical Dependency __Psychiatric __HIV _____ to _____: concerning: _____ Date Date Specific diagnosis or treatment
Revocation	This authorization will remain in effect for a maximum of 12 months from the date of signature and may be cancelled by me in writing at any time. I understand that such cancellation may be harmful to proceedings requiring these records. I do not authorize re-release of this information to anyone. A photocopy or electronic version of this document are both acceptable.
Reason for Disclosure	X Continuing Care __Personal use __Attorney __Insurance __Other (specify)
Authorization	**I Authorize the above provider to release the information marked above to the requester. A photocopy and or electronic document shall be valid as the original.**
	Patient/Guardian Signature _____ Date _____ Relationship to Patient _____

Christopher J Wenner MD, PA will not refuse treatment to any patient that refuses to sign an authorization for release of protected health information. The information once released will no longer be covered under the federal privacy laws. Information not generated by this clinic cannot be released to another facility. The date of signature must not pre-date treatment.