

Frank Y. Wei, M.D., PLLC

Physical Medicine and Rehabilitation

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

Southdale Office
5108 W 74th St Unit 390634
Edina, MN 55439

tel: (952) 926-8925

fax: (952) 920-6338

PATIENT INFORMATION:

NAME: _____ DOB: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: _____

WHO HAS THE INFORMATION THAT YOU WANT RELEASED:

NAME: Frank Wei, MD ATTENTION TO: Medical Records

ADDRESS: 5108 W 74th St Unit 390634 CITY: Edina STATE: MN ZIP: 55439

PHONE: (952) 926-8925 FAX: (952) 920-6338

WHERE DO YOU WANT THE INFORMATION SENT:

NAME: _____ ATTENTION TO: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED:

Routine Record Sets - indicate date(s) of service: _____

- Clinic (office visit, labs, radiology, medicine, immunizations)
 Hospital (history and physical, operative reports, consultations)
 Any and all records (includes ALL types of records listed below)

Only record types checked below:

- Clinic notes Radiology reports
 Therapy notes Disability forms
 Operative reports Work reports
 Consultations Other specific records: _____

PURPOSE OF RELEASE:

- Continuing care Personal use or review
 Insurance purposes Social Security appeal
 Transfer of care Litigation/legal
 Other: _____

RELEASE INSTRUCTIONS:

Date Information needed by: _____

How would you like the records:

Fax Mail Pick Up

This authorization lasts for one year after the date you sign it unless you enter a different date here: _____

This authorization can be canceled at any time in writing. A cancellation will not change release that has happened before the cancellation.

A photocopy/fax authorization will be treated the same way as the original copy.

Your signature below indicates that you have read and understand the form and authorize release of the information stated above.

Patient Signature: _____ Date: _____