Frank Y. Wei, M.D., PLLC

Physical Medicine and Rehabilitation

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

Southdale Office Centre
6600 France Avenue South, Suite 615
Edina, MN 55435

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: 6600 France Ave South, Suite 615 CITY: Edina STATE: MN ZIP: 55435

PHONE: (952) 926-8747 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:______________________