Release of Medical Information

Wensong Li, MD
Anesthesiologist, Interventional Pain Management

Patient's Name_____ **Date of Birth** _____

Address _____**Tel.** _____

I request medical information from: _____
To be disclosed to:

Physician's Name: Wensong Li, MD **Tel**. 718-355-9119 **Fax.** 718-285-9600

Address: _132-61 41st Rd, 201, Flushing, NY 11355 **Dates Seen**:_____

Some medical records may contain extremely confidential information. I do consent to the release of the following information relating to (if left blank, authorization to release information is NOT assumed).

Opioid (controlled substance prescribed) use _____ (initials)
Drug or alcohol abuse _____ (initials)
Mental health conditions _____ (initials)
HIV testing, infection status, or care and treatment for AIDS _____ (initials)

This consent will expire on _____ or 60 days after the date above.

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

_____ _____
Patient, or Guardian's Signature Printed Name

_____ _____ _____
Today's Date Relationship to Patient Witness