



Froedtert Hospital
 9200 West Wisconsin Avenue
 Milwaukee, WI 53226-3596
 Ph: 414-805-2909
 Fax: 414-259-1244

Community Memorial Hospital
 W180 N8085 Town Hall Road
 Menomonee Falls, WI 53051
 Ph: 262-257-3415
 Fax: 262-253-7186

St. Joseph's Hospital
 3200 Pleasant Valley Road
 West Bend, WI 53095
 Ph: 262-836-5057
 Fax: 262-836-8470

Froedtert & The Medical College of Wisconsin Community Physicians
 110 Lone Oak Lane
 Hartford, WI 53027
 Ph: 262-836-2510
 Fax: 262-670-5580

Please complete all items on the form and if you have any questions about this form, please contact the appropriate Health Information Management Department (Medical Records).

1. PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____
 Address: _____ City/State/Zip: _____
 Phone #: _____ Last 4 digits of Social Security #: _____ Medical Record # (if known): _____

2. I AUTHORIZE INFORMATION TO BE RELEASED FROM:

- Community Memorial Hospital
- Froedtert Hospital
- Froedtert Surgery Center
- St. Joseph's Hospital
- West Bend Surgery Center
- Medical College of Wisconsin
- Froedtert & the Medical College of Wisconsin Community Physicians
- Other: Agency/Facility/Person to release the information:
 Name: _____
 Address: _____
 City/State/Zip: _____
 Phone #: _____ Fax #: _____

3. I AUTHORIZE INFORMATION TO BE RELEASED TO:

Agency/Facility/Person _____
 Address _____
 City/State/Zip: _____
 Phone #: _____ Fax #: _____

4. PURPOSE OF DISCLOSURE

- Further Medical Care: Relocating Yes No Insurance Eligibility/Benefits Personal Reasons Disability Determination
- Forms Completion Legal Investigation: Certified Yes No Other: _____

5. TYPE OF PATIENT HEALTH INFORMATION TO BE DISCLOSED

CLINIC	HOSPITAL
<input type="checkbox"/> Clinic records 2-3 year summary <i>For continuing care purposes, a General Abstract will be sent which includes: Progress Notes, Consults, Labs, and Radiology Reports.</i>	<input type="checkbox"/> Hospital Summary <i>A General Abstract will be sent which includes Discharge Summary, H&P, Consults, Operative Reports, Labs, Radiology Reports and ER.</i>
<input type="checkbox"/> Entire medical record for following date(s) of service: From: _____ To: _____	<input type="checkbox"/> Entire medical record for following date(s) of service: From: _____ To: _____
<input type="checkbox"/> Lab Reports: Date(s): _____ <input type="checkbox"/> Radiology Report: Date(s): _____ <input type="checkbox"/> Radiology Image: Date(s): _____	<input type="checkbox"/> Lab Reports: Date(s): _____ <input type="checkbox"/> Radiology Report: Date(s): _____ <input type="checkbox"/> Radiology Image: Date(s): _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

6. RELEASE INFORMATION

Released via: US mail Pick up Fax **Media:** Paper Electronic **My Chart:** Patient Proxy(ies) All

7. AUTHORIZATION IS EFFECTIVE UNTIL

This authorization is effective until _____ (if no date is entered the authorization will be valid for 1 year from date of signature) and includes records that were created or existed on or before the date this authorization was signed.
 This includes records that are created **after** the date this authorization is signed, up until the expiration date. _____ (initials)

8. IMPORTANT INFORMATION

The following information is important for you to read:

- I understand that the information to be disclosed may include information relating to the diagnosis and/or treatment of mental illness, alcohol/drug abuse, STD's, HIV test results, developmental disabilities, and genetic testing results.
- I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released.
- **I understand that I have a right to inspect and/or receive a copy of the health information to be released and I may be charged a fee for any copies of the medical records that I receive.**
- I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described in this form are not health plans, covered health care providers or health care clearinghouses subject to the federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health law.
- I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment.
- A photocopy or fax of this authorization shall be considered as valid as the original.

9. SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

Signature of Patient or Legal Representative _____ Date _____ Time _____

If signed by someone other than the patient, state legal authority:

- Legal guardian of the patient (proof of guardianship required).
- Parent of the above named minor child and I represent that I have not been denied periods of physical placement with my child by a Court.
- The legal representative of a deceased patient (proof required).
- The agent under an activated Healthcare Power of Attorney (proof and statement of incapacity required).

Internal Use: Information released by

Name: _____ Phone #: _____ Records sent from Fax # _____

