Patient Request for Medical Records

For release of information requests made by a patient or patient's representative and to be released to patient or patient's representative or third party.

Date of Request: _____

Name of Person Requesting the Information:_____

Relationship to Patient: (check one) ☐ Self ☐ Patient's Legal Representative

Patient Name: _____ Patient Date of Birth:_____

Patient Address: _____

_____

Preferred Contact Number: _____ ☐ home ☐ mobile

Information Requested (be specific - include provider names, locations, and dates):

Provider Name(s):_____

_____

Locations: ☐ Community Memorial Hospital ☐ Froedtert Hospital ☐ St. Joseph's Hospital
☐ Froedtert Surgery Center ☐ West Bend Surgery Center ☐ Lake Country Surgery Center
☐ Medical College of Wisconsin ☐ F&MCW Community Physicians ☐ Other:_____

Dates:_____

Format requested: ☐ Paper ☐ CD ☐ MyChart (Portal) ☐ Email

**There may be a charge for paper records, a CD or email.*
**By policy, we cannot accept any outside devices, such as flash drives, jump drives or CDs.*

If the records will be sent by email, confirm the email address: _____
**Information released by email may not be secure.*

Name of Person to receive the information: _____

Address: _____

_____

Relationship to Patient: _____

_____ _____ _____
Patient or Patient's Representative Signature Date Time

For Office Use Only:

Identification Confirmed: ☐ Yes ☐ No

Type of identification provided: _____