Froedtert Hospital · 9200 W. Wisconsin Ave., Milwaukee, WI 53226 | Ph: 414-805-2909 • Fax: 414-259-1244
Community Memorial Hospital of Menomonee Falls, Inc. d/b/a Froedtert Menomonee Falls Hospital · W180 N8085 Town Hall Rd., Menomonee Falls, WI 53051 |Ph: 262-257-3415 • Fax: 262-253-7186
St. Joseph's Community Hospital of West Bend, Inc. d/b/a Froedtert West Bend Hospital · 3200 Pleasant Valley Rd., West Bend, WI 53095 | Ph: 262-836-5057 • Fax: 262-836-8490
Holy Family Memorial, Inc. · 2300 Western Ave., PO Box 1450, Manitowoc, WI 54221-1450 · Ph: 920-320-2278 • Fax: 920-320-5118
Froedtert Health Neighborhood Hospital, LLC d/b/a Froedtert Community Hospital · 4805 S. Moorland Rd., New Berlin, WI 53150 | Ph: 262-836-2510 • Fax: 262-836-8490
Froedtert & the Medical College of Wisconsin Community Physicians · 110 Lone Oak Ln., Hartford, WI 53027 | Ph: 262-836-2510 • Fax: 262-836-8490
Medical College of Wisconsin · 10000 Innovation Drive, Ste 300, Milwaukee, WI 53226 · Ph: 262-836-2510 • Fax: 262-836-8490

Patient Request for Medical Records

For questions, please contact the Health Information Management Department (Medical Records) at phone, fax numbers above or email *HealthInformation@froedtert.com*. For Holy Family Memorial Inc. email HFMROI@Froedtert.com

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:

☐ F&MCW Community Physicians ☐ Froedtert Menomonee Falls Hospital ☐ Lake Country Surgery Center
☐ Froedtert Community Hospitals ☐ Froedtert Surgery Center ☐ Medical College of Wisconsin
☐ Froedtert Hospital ☐ Froedtert West Bend Hospital ☐ West Bend Surgery Center
☐ Holy Family Memorial Inc. ☐ 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: _____

This request is effective until_____(if no date is entered the request will be valid for 1 year from the date of signature) and included records that were created or existing on or before the date on this request was signed.

This includes records that are created after the date this request is signed, up until the expiration date. _____ (initials)

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

For Office Use Only:

Identification Confirmed: ☐ Yes ☐ No

Type of identification provided: _____

Authorization, Use/Disclosure of PHI =100139

Original - Medical Records