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: 262-836-8490

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: _____

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