Froedtert Hospital · 9200 West Wisconsin Avenue, Milwaukee, WI 53226-3596 · 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 Road, 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 Road, West Bend, WI 53095 · Ph. 262-836-2510 · Fax 262-836-8490
Froedtert & the Medical College of Wisconsin Community Physicians · 110 Lone Oak Lane, Hartford, WI 53027 · Ph. 262-836-2510 · Fax 262-836-8490
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

Please complete all items on the form and if you have any questions about this form, please contact the Health Information Management Department (Medical Records) at phone, fax numbers above or email HealthInformation@froedtert.com.

1. PATIENT INFORMATION:

Patient Name:_____ Date of Birth:_____

Address:_____ City/State/Zip:_____

Phone #:_____ Medical Record # (if known):_____

2. I AUTHORIZE INFORMATION TO BE RELEASED FROM:

☐ Drexel Surgery Center
☐ Froedtert & the Medical College of Wisconsin Community Physicians
☐ Froedtert Community Hospitals
☐ Froedtert Hospital
☐ Froedtert Menomonee Falls Hospital
☐ Froedtert Surgery Center
☐ Froedtert West Bend Hospital
☐ Lake Country Surgery Center
☐ Medical College of Wisconsin
☐ West Bend Surgery Center
☐ 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

☐ Clinic records 2-3 year summary: Dates _____ to _____
For continuing care purposes, a General Abstract will be sent which includes: Progress Notes, Consults, Labs, and Radiology Reports.
☐ Entire medical record for following **date(s) of service**:
From: _____To:_____
☐ Lab Reports: Date(s): _____
☐ Radiology Report: Date(s): _____
☐ Radiology Image: Date(s): _____
☐ Other:_____

HOSPITAL

☐ Hospital Summary: Dates _____ to _____
A General Abstract will be sent which includes Discharge Summary, H&P, Consults, Operative Reports, Labs, Radiology Reports and ER.
☐ Entire medical record for following **date(s) of service**:
From: _____To:_____
☐ Lab Reports: Date(s): _____
☐ Radiology Report: Date(s): _____
☐ Radiology Image: Date(s): _____
☐ 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, substance use disorder, 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 Only: If releasing records in clinic/facility complete section below:

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

Authorization for Disclosure of Protected Health Information - Form # 37976

Authorization, Use/Disclosure of PHI =100139

ORIGINAL - Medical Records
CANARY - Patient

12/20