

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/h/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/h/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., PÓ 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

Mail. fax. or email to (HealthInformation@froedtert.com) to Froedtert Hospital ATTN: Health Information Department. Hartford Health Center ATTN: Health Information Department or if

this is a Holy Family request use email to: HFMROIRequests@froedtert.com. If y	ou have any questions, please contact Health Information at the numbers above.
1. PATIENT INFORMATION:	
Patient Name:	Date of Birth:
Address:	City/State/Zip:
Phone #: Medical Record # (if known):	
,	3. I AUTHORIZE INFORMATION TO BE RELEASED TO:
☐ Drexel Surgery Center ☐ Froedtert Surgery Center	
☐ Froedtert & the Medical College of ☐ Froedtert West Bend Hospital	
Wisconsin Community Physicians ☐ Lake Country Surgery Center ☐ Froedtert Community Hospitals ☐ Medical College of Wisconsin	Agency/Facility/Person
☐ Froedtert Hospital ☐ West Bend Surgery Center	Address
☐ Froedtert Menomonee Falls Hospital ☐ Holy Family Memorial, Inc.	, tadi 555
Other: Agency/Facility/Person to release the information:	City/State/Zip:
Audress.	Phone #:Fax #:
City/State/Zip:	
Phone #:Fax #:	
4. PURPOSE OF DISCLOSURE ☐ Further Medical Care: Relocating ☐ Yes ☐ No ☐ Insurance Eligibility/Benefits ☐ Personal Reasons ☐ Disability Determination	
 ☐ Further Medical Care: Relocating ☐ Yes ☐ No ☐ Insurance Eligibilit ☐ Forms Completion ☐ Legal Investigation: Certified ☐ Yes ☐ No ☐ 	
	Other
5. TYPE OF PATIENT HEALTH INFORMATION TO BE DISCLOSED CLINIC	HOSPITAL
☐ Clinic records 2-3 year summary: Dates to	☐ Hospital Summary: Dates to
For continuing care purposes, a General Abstract will be sent which includes:	A General Abstract will be sent which includes Discharge Summary, H&P, Consults,
Progress Notes, Consults, Labs, and Radiology Reports.	Operative Reports, Labs, Radiology Reports and ER.
☐ Entire medical record for following date(s) of service: From:To:	☐ Entire medical record for following date(s) of service: From:To:
☐ Lab Reports: Date(s):	□ Lab Reports: Date(s):
☐ Radiology Report: Date(s):	☐ hadiology heport: Date(s):
☐ Radiology Image: Date(s):	☐ Radiology Image: Date(s):
□ Other:	□ Other:
6. RELEASE INFORMATION	
Released via: ☐ US mail ☐ Pick up ☐ Fax	Electronic My Chart: ☐ Patient ☐ Proxy(ies) ☐ All
7. AUTHORIZATION IS EFFECTIVE UNTIL This authorization is offeetive until (if no date is entered the authorization will be valid for 1 year from date of signature) and	
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 not health plans, covered health care providers or health care clearing.	e 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 r A photocopy or fax of this authorization shall be considered as valid 	efusal to sign will not affect my ability to obtain treatment.
9. SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	as the original.
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).	pean denied periods of physical placement with my shild by a Caust
 □ 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 belonger	ow:
Name: Phone #:	Records sent to Fax #

