



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
- Other: Agency/Facility/Person to release the information:

Name: _____
 Address: _____
 City/State/Zip: _____
 Phone #: _____ Fax #: _____

- Froedtert Surgery Center
- Froedtert West Bend Hospital
- Lake Country Surgery Center
- Medical College of Wisconsin
- West Bend Surgery Center

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	HOSPITAL
<input type="checkbox"/> Clinic records 2-3 year summary: Dates _____ to _____ <i>For continuing care purposes, a General Abstract will be sent which includes: Progress Notes, Consults, Labs, and Radiology Reports.</i>	<input type="checkbox"/> Hospital Summary: Dates _____ to _____ <i>A General Abstract will be sent which includes Discharge Summary, H&P, Consults, Operative Reports, Labs, Radiology Reports and ER.</i>
<input type="checkbox"/> Entire medical record for following date(s) of service: From: _____ To: _____	<input type="checkbox"/> Entire medical record for following date(s) of service: From: _____ To: _____
<input type="checkbox"/> Lab Reports: Date(s): _____	<input type="checkbox"/> Lab Reports: Date(s): _____
<input type="checkbox"/> Radiology Report: Date(s): _____ <input type="checkbox"/> Radiology Image: Date(s): _____	<input type="checkbox"/> Radiology Report: Date(s): _____ <input type="checkbox"/> Radiology Image: Date(s): _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> 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 # _____

