Froedtert & Medical College of Wisconsin

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 *HFMROIRequests@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

Name of Person to receive the information: _____

Address:_____

Phone Number:_____ Fax number:_____

Relationship to Patient: _____

Medical Records: **(Be specific; dates, facility and providers)**: _____

_____

Radiology Image date(s) & type (x-ray, CT, MRI, etc.): : _____

_____

Locations:

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

Format requested for records: ☐ MyChart (Patient Portal) ☐ Fax ☐ Paper ☐ CD ☐ Email records

Format requested for X-ray Images: ☐ Radiology images on CD ☐ Email Radiology images

Email address: _____

**By policy, we cannot accept any outside devices, such as flash drives, jump drives or CDs.*

NOTE: Information released by E-mail may not be secure and could be accessed by a third party while being transferred.

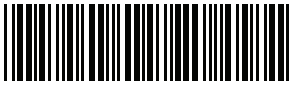
This request is effective until_____(if no date is entered the request will be valid for 1 year from the date of signature) and includes records that were created or existing on or before the date on this request was signed.

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

_____ _____ _____

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