**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

*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 you 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):_____

## 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
☐ Holy Family Memorial, Inc.
☐ 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 #:_____

Email:_____

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

## 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 ☐ Email **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 clearing houses 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

08/24