



9200 West Wisconsin Avenue
Milwaukee, WI 53226
Ph: 414-805-5071
Fax: 414-805-3500

Froedtert HOSPITAL

Froedtert & Community Health
9200 West Wisconsin Avenue
P.O. Box 26099
Milwaukee, WI 53226-3596
Ph: 414-805-2909
Fax: 414-259-1244

Community Memorial HOSPITAL

Froedtert & Community Health
W180 N8085 Town Hall Road
Menomonee Falls, WI 53051
Ph: 262-257-3415
Fax: 262-253-7186

St. Joseph's HOSPITAL

Froedtert & Community Health
3200 Pleasant Valley Road
West Bend, WI 53095
Ph: 262-836-5057
Fax: 262-836-8470

West Bend Clinic

Froedtert & Community Health
1700 West Paradise Drive
West Bend, WI 53095
Ph: 262-334-1641 ext. 2510
Fax: 262-334-5321

Please complete all items on the form and if you have any questions about this form, please contact the appropriate Health Information Management Department (Medical Records).

Patient Name: _____ **Date of Birth:** _____
Address: _____ **City/State/Zip:** _____
Phone Number: _____ **Last 4 digits of patients Social Security #:** _____ **Medical Record Number:** _____

I authorize the information to be disclosed by: Community Memorial Hospital Froedtert Hospital
 Medical College of WI St. Joseph's Hospital West Bend Clinic West Bend Surgery Center

OR
 Other: Agency/Facility/Person to release the information: _____
Address: _____ **City/State/Zip:** _____
Phone Number: _____ **Fax Number:** _____ **Appointment Date (if applicable)** _____

I authorize the information to be disclosed to:
Agency/Facility/Person to receive the information: _____
Address: _____ **City/State/Zip:** _____
Phone Number: _____ **Fax Number:** _____ **Appointment Date (if applicable)** _____

Purpose of Disclosure: Further Medical Care Application for insurance Payment of Insurance Claim
 Disability Determination Legal Investigation Forms Completion Personal Reasons
 Other: _____

Information to Be Disclosed (check all that apply):
Date of Service: _____
 History and Physical Entire Medical Record EKG/Echo ER Record
 Consultation Billing Statements Pathology Report Progress Notes
 Lab Report(s) Discharge Summary Operative Report(s) X-ray/Imaging
 Record(s) Other: _____

***The information to be released via** US mail Pick up Fax Electronic
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)

- 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, alcohol/drug abuse, 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 of this authorization shall be considered as valid 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)
 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)
 Other (specify): _____

Internal Use: Information released by:
Fax Number: _____ **Phone Number:** _____
Completed by: _____ **Location:** _____
If inspected, date and time of inspection: Date: _____ Time: _____

Authorization for Disclosure of Protected Health Information - Form # 37976

Auth for Disclosure of PHI

ORIGINAL - Medical Records
CANARY - Patient



37976

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09/10