

Written authorization from the patient is required. By law, all items must be completed in order to process your request.

1. Print Patient's Name: _____ Phone #: _____

2. Address: _____ City/State/Zip: _____

3. Birth Date: ____/____/____ Social Security #: _____ Medical Record #: _____

4. I authorize the use and/or disclosure of protected health information as described below.

a) Name of person or organization to release the medical record information:

Froedtert Hospital Other _____
9200 W. Wisconsin Ave.
Milwaukee, WI 53226

b) Name of Agency/Facility/ Person authorized to receive the information: _____

Address: _____ City/State/Zip: _____
(If Known)

Appointment Date (If Applicable): _____

c) Dates of Hospitalization or Service: _____

d) Description of Information to be Released: Check all that Apply:

- History and Physical
- Consultation
- Operative Report (s)
- Lab Report (s)
- Other
- Discharge Summary
- X-ray report(s)
- EKG/Echo
- ER Record
- Pathology Report (s)
- CT or MRI Report (s)
- Billing Statements
- CT Image(s)
- Mammogram Image(s)
- MRI Image(s)
- Nuc Med Image(s)
- Ultrasound Image(s)
- Angio Image(s)
- Diagnostic Image(s)

-OR-

Complete Chart (Note: Do not check this box if you only need specific information from a specific date.) Certified Copy

e) Check the reason as to why this information is to be released: (Note: This item is not required if the disclosure is requested by the patient)

- Further medical care
- Disability determination
- Application for insurance
- Legal investigation
- Payment of insurance claim
- Other: _____

5. This authorization is effective until _____ (if no date is entered the authorization will be good for 1 year from date of signature), and covers records that were created or existing on or before the date this authorization was signed, as well as records that are created after the date this authorization is signed, up until the expiration date.

6. I understand that the information to be released may include information relating to the diagnosis and/or treatment of mental illness, alcohol/drug abuse, STD's, HIV tests results, developmental disabilities, and genetic testing results unless I give written instructions not to release such information.

7. 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.

8. I understand that I have a right to inspect and/or receive a copy of the medical information to be released and that I will be charged a fee for any copies of the medical records that I receive.

9. 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.

10. I understand this authorization does not pertain to any protected health information maintained by the Medical College of Wisconsin.

11. I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment.

Signature of Patient or Legal Representative _____

Date _____

If Signed by Legal Representative, relationship to Patient _____

Signature of Witness _____

Information released by: _____

Completed by _____ Location _____

Authorization for PHI



2453

Authorization To Use Or Disclose Protected Health Information - Item # 37976

ORIGINAL - Medical Records
CANARY - Patient

Froedtert HOSPITAL
Froedtert & Commons Health

9200 West Wisconsin Avenue
P.O. Box 26099

82300