Authorization for Release of Protected Health Information

I authorize the following facility(s):

☐ Ascension Wisconsin Hospital – Menomonee Falls
☐ Ascension Wisconsin Hospital – Greenfield
☐ Ascension Wisconsin Hospital – Waukesha

to release information from the record of:

Patient Name:_____ Date of Birth: _____

Address:_____
Street City State Zip code

Patient Phone Number: _____

as described below, the information will be released to:

Facility/Person to Receive Records _____

Phone:_____ Fax/Email: _____

Address:_____
Street City State Zip code

I have been a patient at your facility or am the patient's authorized representative. I understand that the facility has legally protected health information about me or the person I represent. I understand that signing or not signing this form will not affect treatment I receive in any way. The facility cannot require me to sign the authorization in order to receive treatment.

Place a check by types of records desired:

☐ Entire Clinical Record
☐ Discharge Summary
☐ Laboratory Reports/Tests
☐ EKG Report
☐ Nurses Notes
☐ Emergency Department Report
☐ Consultation Reports
☐ History & Physical Exam
☐ Medication Administration Records
☐ Psychiatric/Psychological Evaluation
☐ Radiology Report
☐ Pathology Report
☐ Abstract *(history/physical, consults, labs, EKGs, ORs, D/C summaries, ER reports)*
☐ Billing or other business records *(specify)*: _____
☐ Physician Orders
☐ Physician Progress Reports
☐ Other *(specify)*:_____

HIV, mental health, and drug/alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release:

☐ Drug/Alcohol ☐ HIV ☐ Mental Health (Psychiatric)

Reason for Request:

☐ Continuing treatment ☐ Employer ☐ Insurance ☐ Study/Research
☐ Legal ☐ Disability ☐ I do not wish to disclose the reason
☐ Other: _____

Dates of Service for record requests:_____

This authorization will expire in six months or: _____

A disclosure statement, as required by law, will accompany all records released. Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.

Authorization for Release of Protected Health Information

I understand that this authorization is subject to revocation at any time, except to the extent that Ascension Wisconsin Hospital has already taken action in reliance upon it or to the extent previously disclosed within the HIPAA NOTICE OF PRIVACY PRACTICES for Treatment, Payment, and/or Business Operations. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing and deliver to the Privacy Officer. My decision to revoke the authorization may result in my insurance company not being able to pay for my medical care, and I understand that I may be responsible for payment of the claim. I understand that recipients may redisclose information which I have authorized them to receive, and the information will no longer be protected by federal privacy regulations. If I am physically unable to sign, I may provide oral authorization if witnessed by two (2) staff members.

Patient or Representative Signature _____ Date_____Time_____

If representative, give relationship and authority to act _____

If authority to act is a Power of Attorney, supporting documentation must be included with this request.

Identity of requestor verified via _____ Photo ID _____ Matching Signature _____ Other, Specify _____

Witness Signature _____ Date_____Time_____

Witness Signature _____ Date_____Time_____

All release of information requests must be sent directly to the corresponding facility. The provider's office should be contacted directly to obtain their fax number. Below is the contact information for each hospital.

Ascension Wisconsin Hospital Menomonee Falls
Attn: Medical Records Dept.
N88 W14275 Main St.
Menomonee Falls, WI 53051
Phone: 262-415-2001
Fax: 262-255-3121

Ascension Wisconsin Hospital Greenfield
Attn: Medical Records Dept.
4935 S. 76th
Greenfield, WI 53220
Phone: 414-567-3211
Fax: 414-279-9401

Ascension Wisconsin Hospital Waukesha
Attn: Medical Records Dept.
2325 Fox Run Blvd.
Waukesha, WI 53188
Phone: 262-732-3865
Fax: 262-446-3970