Patient Name: _____

Maiden/Former Name: _____

Date of Birth: _____

Address: _____

_____

Phone Number: _____

Clinic Number (if known): _____

GUNDERSEN HEALTH SYSTEM®

PATIENT RIGHT OF ACCESS
(Release of Information)
1900 South Avenue, AVS-001, La Crosse, WI 54601
PHONE: (800) 362-9567, Ext. 53199 or (608) 775-3199
FAX: (608) 775-4706
EMAIL: medicalrecords@gundersenhealth.org
HOURS: Monday - Friday, 8:00 am – 5:00 pm

1. Disclosed From ☐ GHS (or):

_____
Name (e.g., Health Facility, Physician…)

_____
Street Address

_____
City State Zip

_____
Phone Number Fax Number

2. Disclosed To:

_____
Name (e.g., Insurance Co, Attorney, Physician, Patient…)

_____
Street Address

_____
City State Zip

_____
Phone Number Fax Number

☐ Check box if communication is to be shared between 1 & 2.

3. **Method of Delivery:**
   - ☐ Mail Records *(select format)*
     - ☐ Paper **OR** ☐ Electronic
   - ☐ Fax Records *(provide fax number above)*
   - ☐ MyCare *(if sent to patient only)*
   - ☐ Secure Email: _____
     (Please Print Email Address)
   - ☐ Pick Up Records *(name of clinic)* _____
   - ☐ Verbal Communication between 1 & 2
   - ☐ No records needed at this time

4. **Type of Records to Send:**

_____

_____

2 year history unless specified: _____ to _____
(month/year) (month/year)

Signature of Patient: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____
(If not signed by patient, identify relationship to patient. If Legal Guardian or other, provide a copy of the court order establishing the person's authority.)

Legal Authority:
- ☐ Parent of Minor ☐ Legal Guardian ☐ Spouse of Deceased
- ☐ Personal Representative/Domestic Partner of Deceased
- ☐ Health Care Agent _____
- ☐ Other: _____

INTERNAL USE ONLY (Document PHI disclosed, date of disclosure and by whom.)