Tomah Health
TOGETHER IN CARE

Patient Name: _____
Maiden/Former _____
Date of Birth: _____
Address: _____
Phone Number: _____
Clinic Number: _____

PATIENT RIGHT OF ACCESS
(Release of Information)
501 Gopher Drive
Tomah, WI 54660
(608) 372 - 2181
Fax: (608) 377-8743

1. Disclosed From [ ] Tomah Health (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)
- ☐ MyChart (if sent to patient only)
- ☐ Secure Email: _____
- ☐ Pick Up Records
- ☐ Verbal Communication between 1 & 2
- ☐ No records needed at this time

4. Type of Records to Send:

_____

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

11/2023