

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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):** **2. Disclosed To:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (e.g., Health Facility, Physician...) Name (e.g., Insurance Co, Attorney, Physician, Patient... )

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address Street Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip City State Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number Fax Number 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.)

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

**Legal Authority:**

[ ] Parent of Minor [ ] Legal Guardian [ ] Spouse of Deceased

[ ] Personal Representative/Domestic Partner of Deceased

[ ] Health Care Agent:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Page 1 of 1

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