WESTERN WISCONSIN HEALTH PATIENT ACCESS REQUEST FOR HEALTH INFORMATION

1100 Bergslien Street • Baldwin, WI 54002 • Health Information Management Department • Phone 715-684-1590 • Fax 715-684-1594

Patient Information:

Patient name: _____ Date of Birth: _____
Previous name(s): _____ MRN: _____
Address: _____ Phone: _____
City: _____ State: _____ ZIP: _____
Email: _____ Fax: _____

Health Information Released TO:

*(**Where** do you want the information sent?)*

☒ Self

I am requesting a copy of my health records that are maintained by Western Wisconsin Health for my personal review.

Health Information to be Released:

*(**What** information do you want released? Check the appropriate box)*

Indicated date(s) of service: ____/____/____ through ____/____/____

☐ Discharge Summary	☐ Radiology reports	☐ Medication/Allergy record	*Behavioral Health Specific:*
☐ Operative report	☐ Laboratory reports	☐ Immunizations	☐ Intake Assessment
☐ History & Physical	☐ Pathology reports	☐ Billing Records	☐ Treatment Plan
☐ Emergency records	☐ Diagnostic Test results	☐ Copies of Films/Images	☐ Psychological Testing
☐ Progress Notes	☐ Rehab records (PT/OT/ST)	☐ Other: _____	☐ Psychiatric Evaluation

All records pertaining to Behavioral/Mental Health, HIV/HIV related illness and Alcohol and/or drug abuse will be released unless indicated here. Do **NOT** release records/information related to:

☐ Behavioral/Mental Health ☐ HIV/HIV related illness ☐ Alcohol and/or drug abuse

Release Instructions:

*(**How** and **When** do you want the information?)*

Date information is needed: _____ **(NOTE: PLEASE ALLOW 7 BUSINESS DAYS FOR PROCESSING)**

Delivery / Format method:

☐ Mail – Paper	☐ Pick up – Paper	☐ Fax – Paper
☐ Mail – PDF on USB Drive	☐ Pick up – PDF on USB Drive	☐ MyChart – PDF sent to MyChart
☐ Mail – CD (only for Imaging)	☐ Pick up – CD (only for Imaging)	☐ Other: _____
☐ Secure E-mail – PDF	☐ Unsecure* E-mail – PDF	

*NOTE: I acknowledge that by electing to receive my health information via email in a non-secure manner that the information will not be encrypted, and that it could be intercepted and viewed by a third party. Western Wisconsin Health is not responsible for unauthorized access of your health information while in transmission to the email address you designated above.

Signature requirements:

_____ _____
Patient/Legal Representative's Signature (include relationship if other than patient) Date

For questions call Western Wisconsin Health Release of Information at: 715-684-1590

Completed forms can be sent via:
Fax: 715-684-1594
Email: HIMTeam@wwhealth.org
Mail: Western Wisconsin Health, Attn: Release of Information
1100 Bergslien Street, Baldwin, WI 54002

OFFICE USE ONLY:	Completion Date: _____ Clinic/Nursing Staff (Initials):_____ ROI/HIM Staff (Initials): _____ Photo ID: _____