Group Health Cooperative of South Central Wisconsin

Patient Request for Health Information Form

Patient Information (Please Print)

Name – Last, First MI			
Street Address	City	State	Zip
Medical Record/Member #	Date of Birth (MM/DD/YYYY)	Phone number	

What records do you want? (Check appropriate boxes below):

Date(s) of Service: _____ through _____

☐ Billing Records ☐ Office Visits ☐ Eye Care Notes ☐ Complementary Medicine

☐ Mental Health ☐ Procedures ☐ X-Ray Images ☐ Physical/Occupational Therapy

☐ Test Results (X-Ray, Lab/Pathology Results) Please specify: _____

☐ Other (Immunization Records, Medication Lists) Please specify: _____

How would you like your records delivered? (Check appropriate boxes below):

☐ Paper

☐ Home Delivery

☐ In-person Pickup: Administrative Building – 1265 John Q Hammons Drive, Madison, WI 53717
(Please allow up to 5 business days for request processing)

☐ Electronic (Email, CD, USB, MyChart, Other) Please specify: _____

(If unencrypted, requester was informed and understands the risks of receiving records via unsecured mail and that personal health information could be accessed by a third party while in transit. Requester still wants the records in this manner)

Where do you want the information sent? (Fill in boxes below):

GHC-SCW should provide my records to: ☐ Self ☐ Personal Representative/Third Party (indicated below)

☐ Mail To: _____
Name of Personal Representative/Third Party

_____
Address City State

☐ Email address (the email will be encrypted unless specified otherwise): _____

☐ Fax To: _____

Signature of Patient or Personal Representative: _____ Date: _____

Relationship: _____ Legal Authority: □ Legal Guardian □ Spouse of Deceased

Patient is: □ Minor □ Incompetent/Incapacitated □ Deceased □ Health Care Agent □ Personal Representative

□ Other: _____

GHC-SCW recognizes a patient's right under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.

☐ *HIM Department Verification (Staff initial box when verification has been confirmed):*
Demographic information (Name, DOB, Address, Phone Number, Email Address, Last 4 digits of SSN)