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 (Please allow up to 5 business days for request processing)

☐ East Clinic – 5249 East Terrace Drive, Madison, WI 53718

☐ Administrative Building – 1265 John Q Hammons Drive, Madison, WI 53717

☐ 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: _____

Patient is: ☐ Minor ☐ Incompetent/Incapacitated ☐ Deceased

Legal Authority: ☐ Legal Guardian ☐ Spouse of 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)*