



OAKLEAF
SURGICAL HOSPITAL

REQUEST TO INSPECT OR COPY PROTECTED HEALTH INFORMATION

PATIENT:

Patient Name/Previous Name(s)

Date of Birth

Street Address, City, State, Zip Code

Phone Number

RELEASE MY PROTECTED HEALTH INFORMATION TO: Myself Individual Noted Below

Individual Name _____

Business Office (if applicable): _____

Street Address _____

City, State, Zip Code _____

Phone # _____ Fax # _____

INFORMATION TO BE DISCLOSED

Date(s) of Service: _____

___ History & Physical

___ Operative Reports

___ Radiology Reports

___ Progress Notes

___ EKG Reports

___ Other _____

___ Discharge Summary

___ Laboratory Reports

___ Consultations

___ Pathology Reports

In compliance with Wisconsin Statutes, to release privileged information, please release records pertaining to:

___ Mental Health

___ Developmental Disabilities

___ Alcoholism

___ HIV (AIDS)

___ Sexually Transmitted Disease

___ Drug Abuse

We may be prohibited from making certain information available to you or to your representative, including:

- Psychotherapy notes
- Information related to medical research in which you have agreed to participate
- Information related to legal proceedings
- Information obtained under a promise of confidentiality
- Information that federal or state laws prevent us from disclosing
- Information related to medical research in which you have agreed to participate
- Information for which the disclosure may result in harm or injury to your or to another person

This information is to be: Mailed Pickup Fax Inspect Other _____

Please choose format: Paper Copy Electronic Media

YOUR RIGHTS WITH RESPECT TO THIS REQUEST:

Within the limitations of law, we will make every effort to accommodate your request. We will complete our review of your request and as requested either provide a copy or arrange for you to inspect your records within 30 days of your request, or provide you with a written explanation of any restriction on the information that we can provide you.

Printed Name of Patient

Signature of Patient or Legal Representative/Relationship

Date

Mailing Address: OakLeaf Surgical Hospital – ROI, 1000 OakLeaf Way, Altoona, WI 54720 or Fax 715.839-7141