OAKLEAF
SURGICAL HOSPITAL
physician owned. patient centered.

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
___Progress Notes
___Discharge Summary
___Consultations
___Operative Reports
___EKG Reports
___Laboratory Reports
___Pathology Reports
___ Radiology Reports
___ Radiology Images/CD
___Abstract
___Other_____

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

___Mental Health
___HIV (AIDS)
___Developmental Disabilities
___Sexually Transmitted Disease
___Alcoholism
___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.

_____ _____
Signature of Patient or Legal Representative/Relationship Date

_____
Printed Name of Patient

Mailing Address: OakLeaf Surgical Hospital – ROI, 1000 OakLeaf Way, Altoona, WI 54720 or ROI Fax 715.952.0972

Revised 10.18.18

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Staff Initials