



Patient Name: _____
Maiden/Former _____
Date of Birth: _____
Address: _____
Phone Number: _____
Clinic Number: _____

PATIENT RIGHT OF ACCESS
(Release of Information)
501 Gopher Drive
Tomah, WI 54660
(608) 372 - 2181
Fax: (608) 377-8743

1. Disclosed From [] Tomah Health (or):

2. Disclosed To:

Name (e.g., Health Facility, Physician...)

Name (e.g., Insurance Co, Attorney, Physician, Patient...)

Street Address

Street Address

City State Zip

City State Zip

Phone Number Fax Number

Phone Number Fax Number

[] Check Box if communication is to be shared between 1 & 2

3. Method of Delivery:

- [] Mail Records (select format)
 [] Paper **OR** [] Electronic
[] Fax Records (provide fax number above)
[] MyChart (if sent to patient only)
[] Secure Email: _____
[] Pick Up Records
[] Verbal Communication between 1 & 2
[] No records needed at this time

4. Type of Records to Send:

2 year history unless specified: (month/year) _____ to (month/year) _____

Signature of Patient: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____

(If not signed by patient, identify relationship to patient. If Legal Guardian or other, provide a copy of the court order establishing the person's authority.)

Legal Authority:

- [] Parent of Minor [] Legal Guardian [] Spouse of Deceased
[] Personal Representative/Domestic Partner of Deceased
[] Health Care Agent: _____
[] Other: _____

INTERNAL USE ONLY (Document PHI disclosed, date of disclosure and by whom.)