Patient Name:_____

Former Name(s):_____

Date of Birth:_____

Address: _____

Phone Number:_____

Medical Record Number (if known): _____

GUNDERSEN HEALTH SYSTEM®

1900 South Avenue, NCA2-08, La Crosse, WI 54601
PHONE: (800) 362-9567, Ext. 53199 or (608) 775-3199
Fax/Email **REQUESTS FOR GHS RECORDS** to:
medicalrecords@gundersenhealth.org or (608) 775-4706
Fax/Email **RECORDS FROM OUTSIDE FACILITIES** to:
himscanning@gundersenhealth.org or (608) 775-5130

I hereby Authorize: Written and Verbal Communication Between 1 & 2.

1. **Release Information FROM**:

_____
Name (i.e. Gundersen, Health Care Facility, Provider)

_____
Street Address

_____
City State Zip

_____
Phone Number Fax Number

2. **Release Information TO**: (Need FULL mailing address)

_____
Name (i.e. Insurance Company, Lawyer, Provider)

_____
Street Address

_____
City State Zip

_____
Phone Number Fax Number

3. **Please CHECK ONLY ONE BOX:**
   ☐ Mail Records ☐ Fax Records (provide fax number above) ☐ Email: _____
   ☐ MyChart Patient Portal ☐ No records needed at this time. File in patient's medical record for future use.

4. **If Mailing Records, Format for Records:** ☐ Paper **OR** ☐ CD/DVD (requires PDF viewer). Please check only one box.
   ***Please note, if a format is not selected, records will be provided in paper format**

5. **Type of Information to Be Disclosed:** ☐ Summary (last 2 years) ☐ Records pertaining to (dates/conditions):_____

   Entire Medical Record from:_____ to _____ ☐ Other (describe):_____

6. **State and Federal Laws require specific authorization prior to disclosing certain information. Please check if you would like any or all of the following information disclosed:**
   ☐ Mental Health ☐ Substance Use Disorder ☐ Developmental Disability ☐ HIV Test Results

7. **Purpose or need for disclosure (check one):** ☐ Healthcare ☐ Insurance ☐ Personal ☐ Legal ☐ Other:_____

8. **Expiration Date:** This authorization is valid for 2 years from date of signature unless you specify a shorter time frame. This authorization covers records that were created or existing, on or before the date this authorization was signed, as well as records that are created after the date this authorization is signed, up until expiration date. ☐ Other specific expiration date:_____

Your Rights with Respect to This Authorization

Right to Receive a Copy of this Authorization: I have a right to receive a copy of this authorization after I sign it. **Right to Refuse to Sign This Authorization:** I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment. **Right to Revoke This Authorization:** I have the right to revoke this authorization at any time by providing a written statement of revocation to Gundersen's Privacy Office. My revocation will not be effective until the Gundersen's Privacy Office receives it and will not be effective regarding the uses and/or disclosures of my protected health information made prior to receipt of my revocation statement. **Re-disclosure:** If I authorize release of my protected health information to an individual or agency not covered by federal or state laws that prohibit re-disclosure, my protected health information may not remain confidential. **Right to Inspect and/or Copy of My Protected Health Information:** I have the right to inspect and receive copies of my protected health information as permitted by law.

In accordance with the conditions listed above, I authorize the use and/or disclosure of my protected health information.

Signature of Patient/Representative:_____ **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: _____