Patient Name: _____

Former Name(s): _____

Date of Birth: _____

Address: _____

Phone Number: _____

Medical Record Number (if known): _____

GUNDERSEN HEALTH SYSTEM®

PATIENT RIGHT OF ACCESS

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

1. **Disclosed From** ☐ GHS (or):

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

_____
Street Address

_____
City State Zip

_____
Phone Number Fax Number

2. **Disclosed To**:

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

_____
Street Address

_____
City State Zip

_____
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: _____
     (Please Print Email Address)
   - ☐ Pick Up Records *(name of clinic)* _____
   - ☐ No records needed at this time

4. **Type of Records to Send:**

_____

_____

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