Aurora Health Care® Milwaukee, Wisconsin

PATIENT HEALTH INFORMATION ACCESS REQUEST FORM

MRN: ______________________

Today's Date: ________________

Patient Information:

____

First Name MI Last Name

Address: ________________________________ City: ________________ State: _____ Zip: ___________

Date of Birth: ______________ Phone Number: ________________ Previous Name: ___________________

Request that Aurora Health Care disclose my health information to:

☐ Myself or ☐ ____

Name of Health Care Provider / Insurance / Attorney / Other

Delivery Method Requested:

☐ Mail To: ____

Address City State Zip

☐ Email address: ____

Format Requested (Fees may apply):

☐ Encrypted CD ☐ Paper ☐ Other ____

☐ Encrypted email ☐ Non-Encrypted email (Requestor was informed and understands the risks of receiving records via unsecured email and that personal health information could be accessed by a third party while in transit. Requestor still wants the records in this manner.)

Information to be Disclosed and Dates:

☐ Billing Records related to (specify): ____

☐ Emergency Department Reports

☐ Hospital Summary – a general abstract will be sent which includes Discharge Summary, H&P, Consults, Operative Reports, Labs, Radiology Reports & ER.

☐ Imaging Films (X-ray)

☐ Imaging Results

☐ Immunizations

☐ Lab Reports

☐ Procedure Op Reports

☐ Progress Notes/Updates

☐ Other: ______________________________

Patient/Personal Rep Signature: ____

Print Name and Signature

Aurora will accept any written request from a patient for access to or copies of their own medical record. This form is not required. However, it will provide Aurora with all needed information to assure an accurate response.

For Office Use Only:

Health Information Department Verification (Staff *initial* box when verification has been confirmed):

☐ Demographic information (Name, DOB, Address, Phone Number, email address, last 4 digits of SS#)

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