Patient name			
MHN	DOB	Age	Gender

Patient Access

Release of Information Request

Patient address		Request date (month/day/year) / /
City	State	ZIP code

TYPE OF ACCESS AND INFORMATION REQUESTED

Would you like to inspect or obtain a copy of your records: ☐ Inspect on-site ☐ Copy

For what type of record: ☐ My medical records ☐ My mental health records ☐ My billing records
☐ My test results ☐ My radiology images ☐ Other, specify _____

For what time period: From (m/d/y) _____ /_____ /_____ to (m/d/y) _____ /_____ /_____ ☐ All ☐ Update

Method of release: ☐ Paper ☐ Email (use of encryption required) Email address _____
☐ Pick-up (Number to call _____ Preferred center for pick-up _____)
☐ Mailed (Specify the name and address below)
Name _____
Address _____

The purpose of this request is: ☐ Continuing health care needs ☐ Personal ☐ Transfer of care ☐ Litigation
☐ Second opinion/referral ☐ Disability determination (for insurance or government)
☐ Other, specify _____

I understand that Marshfield Clinic Health System will notify me of its decision to approve or deny my request to inspect or obtain a copy of my records within thirty (30) days of receiving this request if the information is maintained or accessible on-site or within sixty (60) days if the information is not maintained or accessible on-site. If Marshfield Clinic Health System is unable to comply with my approved request for information maintained or accessible on-site within thirty (30) days, it may extend the deadline for up to thirty (30) more days by notifying me in writing.

Except as otherwise allowed under applicable law, I understand that I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by Marshfield Clinic Health System who did not participate in Marshfield Clinic Health System's decision to deny my request.

_____ _____ _____/_____/_____ _____
Patient signature (Person authorized to consent for patient signature) (Relationship to patient) Signature date (m/d/y) Phone no.

Minor patient signature (if applicable) _____ Signature date (m/d/y) _____ /_____ /_____

Send completed request to Release of Information, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, WI 54449
Fax: 715-221-6992 E-mail: medicalrecords@marshfieldclinic.org

FOR MARSHFIELD CLINIC HEALTH SYSTEM INTERNAL USE ONLY

Date received (m/d/y) _____ /_____ /_____

☐ Accepted ☐ Denied

If denied, check reason for denial:
☐ PHI is compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding
☐ PHI is not available to the patient for inspection or copying as permitted or required by state or federal law
☐ PHI is not part of patient's designated record set
☐ Other (see comments below)

Comments: ☐ Individual was informed of denial in writing (attach letter of communication)

_____ _____/_____/_____
Staff member signature/title Date (month/day/year)

