Patient Name: ______________________________
Maiden/Former Name: ______________________
Date of Birth: ______________________________
Address: ___________________________________
_________________________________________
Phone Number: ____________________________
Clinic Number (if known): ___________________


**GUNDERSEN**
**HEALTH SYSTEM®**

**La Crosse, WI 54601**
1900 South Avenue, AVS-001, La Crosse, WI 54601
PHONE: (800) 362-9567, Ext. 53199 or (608) 775-3199
**FAX: (608) 775-4706**
EMAIL: medicalrecords@gundersenhealth.org
HOURS: Monday - Friday, 8:00 am – 5:00 pm


1. **Disclosed From** ☐ GHS (or):

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

_________________________________________
Street Address

_________________________________________
City State Zip

_________________________________________
Phone Number Fax Number

2. **Disclosed To**:

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

_________________________________________
Street Address

_________________________________________
City State Zip

_________________________________________
Phone Number Fax Number

☐ Check box if communication is to be shared between 1 & 2.

1. **Method of Delivery:**
   - ☐ Mail Records *(select format)*
     - ☐ Paper **OR** ☐ Electronic
   - ☐ Fax Records *(provide fax number above)*
   - ☐ MyCare *(if sent to patient only)*
   - ☐ Secure Email: _______________________________________________
     (Please Print Email Address)
   - ☐ Pick Up Records *(name of clinic)* ____________________________________
   - ☐ Verbal Communication between 1 & 2
   - ☐ No records needed at this time

2. **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: ______________________________

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


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Gundersen Tri-County Hospital and Clinic, Gundersen St. Joseph's Hospital and Clinics
Gundersen Boscobel Area Hospital and Clinics, Gundersen Palmer Lutheran Hospital and Clinics