REQUEST FOR ACCESS TO INSPECT/COPY OR AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

You or your personal representative can use this form to request access to your protected health information or for disclosure of your protected health information to others. You may also write a letter containing the same information as requested in this form.

Please mail or deliver your Request to Inspect/Access or to Disclosure to:

Attn: Medical Records Office
Lasata Senior Living Campus
W76 N677 Wauwatosa Road
Cedarburg, WI 53012

Name _____ Phone _____

Address _____

Specify the records you wish to inspect or copy:_____

_____

_____

Specify the timeframe of the records you wish to inspect or copy:_____

_____

Individual or entity to whom records should be disclosed: _____

_____

Address where copies of records should be mailed: _____

_____

_____ _____
Signature of Resident Date

_____ _____
Signature of Personal Representative Date
(If requestor is a Personal Representative, a copy of Documentation supporting the representation must be provided with this request.)

REQUEST FOR ACCESS/DISCLOURE

FOR INTERNAL USE ONLY:

Date request received: _____

Time request received: _____

Date of inspection: _____

Name of inspector: _____

Records inspected: _____

Date copies provided: _____

Name of person copies provided to: _____

Records copied: _____

Address copies mailed to: _____

THIS REQUEST FOR ACCESS/DISCLOSURE AND RELATED DOCUMENTATION SHALL BE MAINTAINED IN THE INDIVIDUAL'S HEALTH CARE RECORDS FOR A MINIMUM OF SIX YEARS OR LONGER AS NECESSARY TO COMPLY WITH RECORD RETENTION REQUIREMENTS.