1. Patient Name: ______________________

Maiden/Former Name: __________________

Date of Birth: _________________________

Address:_____________________________

____

Phone Number: ________________________

Medical Record # (if known): ______________

Boscobel Area Hospital and Clinics
205 Parker Street, Boscobel, WI 53805
PHONE: (608) 375-6232
FAX: (608) 375-4213
EMAIL: cawalker@gundersenhealth.org
HOURS: Monday - Friday, 8:00 am – 4:30 pm

2. I Am Requesting My Records Be Sent to:

____

Name of Person or Organization(Gundersen Health System)

____

Street Address

____

City State Zip

____

Phone Number Fax Number

3. Method of Delivery:

- ☐ Mail Records
  - ☐ Paper **OR**
  - ☐ Electronic
- ☐ Fax Records (provide fax number above)
- ☐ MyCare (if sent to patient only)
- ☐ Secure Email: ____
  (Please Print Email Address)
- ☐ Pick Up Records **(Boscobel Campus ONLY)**

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: _____________________________________

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