

Franciscan Skemp
Mayo Health System

1. **Patient Name:** _____ **Previous/Maiden Name:** _____

Address: _____

Phone Number: _____

Date of Birth: _____

2. **Authorizes:**

Name of Healthcare Provider/Plan/Other

Street Address

City, State, Zip Code

3. **To Release to:**

Franciscan Skemp Healthcare
Name of Healthcare Provider/Plan/Other

Street Address

City, State, Zip Code

4. **Information to be Released for the following dates:** _____

- Specify if Necessary:**
- | | |
|--|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> X-ray Reports |
| <input type="checkbox"/> History & Physical/Diagnostic Summary | <input type="checkbox"/> X-ray Films |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Office visit notes |
| <input type="checkbox"/> Billing records | <input type="checkbox"/> Entire Medical Record |
| <input type="checkbox"/> Other (specify): _____ | |

In compliance with state statutes (252.15 & 51.30), which require special permission to release otherwise privileged information, please release records pertaining to:

- Behavioral Health Care/Psychiatric care
- Alcohol and/or Drug Abuse Treatment
- AIDS/HIV and other communicable Disease
- Other (Specify): _____

5. **Purpose for Need of Disclosure:** (check applicable categories)

- | | |
|--|--|
| <input checked="" type="checkbox"/> Further Medical Care | <input type="checkbox"/> Legal Investigation or Action |
| <input type="checkbox"/> Insurance Eligibility/Benefits | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Changing Physicians |
| <input type="checkbox"/> Other (Specify) _____ | |

I understand, by signing this authorization that treatment, payment, enrollment or eligibility may not be conditioned by signing this authorization. This authorization may be revoked, in writing, at any time prior to the disclosure of this information. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim. This information is intended only for the use of the individual or entity to which it is addressed and contains information that is **confidential**. Furthermore, this information may be protected by numerous Federal laws relating to confidentiality prohibiting any further disclosure. I also understand I have the right to inspect and receive (upon reasonable notice and for a reasonable fee) a copy of the material to be disclosed as well as a copy of this authorization form. If not previously revoked, this authorization will expire six (6) months from the date of my signature. A photocopy of this authorization is considered as valid as the original.

PATIENT SIGNATURE

DATE

TIME

SIGNATURE OF LEGAL REPRESENTATIVE

WITNESS

RELATIONSHIP TO PATIENT

**AUTHORIZATION FOR RELEASE
OF HEALTH INFORMATION**

FRANCISCAN SKEMP HEALTHCARE
LOCATIONS

FSH – La Crosse Campus (608) 785-0940
Clinic Medical Records Hospital Medical Records
800 West Avenue South 700 West Avenue South
La Crosse, WI 54601 La Crosse, WI 54601

Patient Financial Services
603 S 10th St
La Crosse, WI 54601

FSH – Arcadia Campus
464 S St Joseph Street
Arcadia, WI 54612
Phone # 608-323-3341
Fax # 608-323-3795

FSH – Caledonia Clinic
701 N Sprague
Caledonia, MN 55921
Phone # 507-724-3353
Fax # 507-724-5650

FSH – Prairie Du Chien Clinic
800 E Blackhawk Avenue
Prairie Du Chien, WI 53821
Phone # 608-326-0808
Fax # 608-326-0810

FSH – Holmen Clinic
520 Amy Drive
Holmen, WI 54636
Phone # 608-526-3351
Fax # 608-526-3412

FSH – La Crescent Clinic
524 N Elm St
La Crescent, MN 55947
Phone # 507-895-6600
Fax # 507-895-6599

Occupational Health
630 S. 10th Street
La Crosse, WI 54601
Phone # 608-791-9769
Fax # 608-791-9567

FSH – Lake Tomah Clinic
325 Butts Ave
Tomah, WI 54660
Phone # 608-372-5951
Fax # 608-372-3436

FSH – Onalaska Clinic
191 Theater Road
Onalaska, WI 54650
Phone # 608-783-2200
Fax # 608-781-1169

FSH – Sparta Campus
310 W Main St
Sparta, WI 54656
Phone # 608-269-2132
Fax # 608-269-1017

FSH – Waukon Clinic
105 E Main St
Waukon, IA 52172
Phone # 563-568-3449
Fax # 563-568-4947