Reset

MAYO CLINIC

Authorization to Disclose Protected Health Information to Mayo Clinic

Patient Name	Date of Birth *(mm/dd/yyy)*
Address	
Mayo Clinic Medical Record Number	Daytime Telephone Number

I hereby authorize _____
(Name/Address of Health Care Provider and/or Institution)

("Disclosing Party") to disclose the following Protected Health Information pertaining to the above-referenced patient (check the appropriate items, and specify physician/provider names and dates/date ranges, when known):

- ❑ Pertinent Information (i.e., all physician/provider transcribed note[s] and all diagnostic test result[s]):
- ❑ Discharge Summary _____
- ❑ History and Physical Exam(s) _____
- ❑ Laboratory Result(s) _____
- ❑ X-ray(s) and/or imaging report(s) _____
- ❑ Other specialty exam(s) and/or test(s) _____
- ❑ Operative and/or procedure report(s) _____
- ❑ Entire medical record _____
- ❑ Billing record(s) _____
- ❑ Other, please specify document(s) _____

I understand this authorization covers records relating to communicable diseases, acquired immunodeficiency syndrome ("AIDS"), human immunodeficiency virus ("HIV"), behavioral and/or mental health care, alcohol and/or drug abuse treatment, and genetic testing, if any such information exists.

Such records shall be disclosed to Mayo Clinic and sent to:

❑ Mayo Clinic Building - Scottsdale
13400 East Shea Boulevard
Scottsdale, Arizona 85259
Attention: _____

❑ Mayo Clinic Hospital
5777 East Mayo Boulevard
Phoenix, Arizona 85054
Attention: _____

❑ Mayo Clinic Specialty Building
5777 East Mayo Boulevard
Phoenix, Arizona 85054
Attention: _____

❑ Mayo Clinic Building - Phoenix
5881 East Mayo Boulevard
Phoenix, Arizona 85054
Attention: _____

❑ Please process as a STAT request - patient in the hospital. Fax information to: _____

This information will be disclosed for the following purposes (check the appropriate items):
❑ Continued Patient Care ❑ Other (specify) _____

I understand that my health care providers will not condition treatment on whether I sign this authorization.

I understand that I have the right to revoke this authorization at any time except to the extent that the Disclosing Party has already taken action in reliance on it. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the Disclosing Party. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that this authorization will expire one year from the date of signing unless otherwise specified:

I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or entity that receives the information.

Signature	Date *(mm/dd/yyyy)*
Print Name	Relationship to Patient (if not patient)

Print