MAYO CLINIC

Medical Records Release

List every hospital/clinic where you received treatment for mitochondrial disease:

Hospital/Clinic name _____ _____ _____

Street Address _____ _____ _____

City, State Zip Code _____ _____ _____

Re: Patient name: _____

Date of Birth: _____

Purpose for release of information: inclusion in a research database.

Information requested- all medical records including, but not limited to: history and physical, consultation notes, inpatient, outpatient and emergency room treatment, clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge summaries, laboratory records, requests for and reports of consultants, and correspondence.

I hereby authorize the release of medical records detailed above to the Mitochondrial Disease Biobank at Mayo Clinic.

Mitochondrial Disease Biobank
Mayo Clinic
Hilton 3-30
200 First Street SW
Rochester, MN 55905

Please contact the Mitochondrial Disease Biobank project coordinator at 507-293-1386, 1-877-594-2149 or mitochondrialdb@mayo.edu if you have additional questions.

I understand the following:

- I have a right to revoke this authorization in writing at any time, but that will not affect information that has already been released.
- The information released in response to this authorization may be shared with other research institutions. Mayo Clinic cannot guarantee that personal information released to outside institutions will be kept private, although all reasonable measured will be taken to protect your privacy.
- The treatment my doctor gives me will be the same whether or not I sign this form.

Any facsimile, copy, or photocopy of this authorization shall authorize you to release the records requested here. This authorization shall last forever unless revoked by the patient in writing.

_____

Signature of Patient or Legally Authorized Representative (Date)

_____

Printed Name of Participant or Representative

_____

Relationship of Legally Authorized Representative to Patient

MAYO CLINIC

Clinical Specimen Release

List every hospital/clinic where you have had a biopsy or other tissue sampling done:

Hospital/Clinic name	_____	_____	_____
Street Address	_____	_____	_____
City, State Zip Code	_____	_____	_____

Re: Patient name: _____

Date of Birth: _____

Purpose for release of specimens: inclusion in a research database.

Information requested: all residual clinical specimens including, but not limited to autopsy, laboratory, histology, cytology, pathology, and immunohistochemistry records and specimens.

I hereby authorize you to release and send the residual clinical specimens detailed above to The Mitochondrial Disease Biobank:

BAP Laboratory
Mayo Clinic
Stabile 13-10
221 4th Avenue SW
Rochester, MN 55905-0014
Telephone: 507-538-7062

I understand the following:

- I have a right to revoke this authorization in writing at any time, but that will not affect information that has already been released.

- The information released in response to this authorization may be shared with other research institutions. Mayo Clinic cannot guarantee that personal information released to outside institutions will be kept private, although all reasonable measured will be taken to protect your privacy.

- The treatment my doctor gives me will be the same whether or not I sign this form.

Any facsimile, copy, or photocopy of this authorization shall authorize you to release the specimens requested here. This authorization shall last forever unless revoked by the patient in writing.

_____

Signature of Patient or Legally Authorized Representative (Date)

_____

Printed Name of Participant or Representative

_____

Relationship of Legally Authorized Representative to Patient