Reset Form

TO BE SCANNED

MAYO CLINIC

Authorization to Release Protected Health Information

Form content retained in medical record. **Route to scanning.**

Instructions: <u>All</u> sections need to be completed to be a valid authorization.

1. Legal Name *(Last, First, Middle)*	Previous Name		Medical Record Number
Address *(Street)*	Phone Number		Cell Phone Number
City	State	ZIP Code	Birth Date

2. Release Information From

Mayo Clinic Health System Attn: _____

- ☐ 300 State Avenue, Faribault, MN 55021 Fax: 507-422-0902
- ☐ Crossroads Building: 1575 20th St. NW, Fairbault, MN 55021
- ☐ 225 Huseth Street, Kenyon, MN 55946
- ☐ 2200 26th Street NW, Owatonna, MN 55060 Fax: 507-422-0902
- ☐ Other *(Specify facility/dept/individual & address below, including phone/fax if known.)*

_____

_____

_____

3. Release Information To

Mayo Clinic Health System Attn: _____

- ☐ 300 State Avenue, Faribault, MN 55021 Fax: 507-422-0902
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- ☐ Other *(Specify facility/dept/individual & address below, including phone/fax if known.)*

_____

_____

_____

4. Purpose of Release

☐ Treatment/Continued Care ☐ Personal ☐ Legal Purposes ☐ Transfer of Care

☐ Application for Insurance ☐ Disability Determination ☐ Payment of Insurance Claim ☐ No Records Needed at this Time - Keep on File

☐ Other _____

5. Release type: ☐ Verbal (no copies) ☐ Hard Copy ☐ Review of record (no copies)

6. Information to be Released

Service Dates (Optional) **From** **To**

Date Information Needed By

☐ 2 Year History	☐ Forms	☐ Medications/Allergies	☐ Psychological Testing	☐ Other _____
☐ Clinic Notes	☐ Hospital Notes	☐ Phys/Occ/Sp Therapy	☐ Radiology Images	_____
☐ EKG's/Cardio/Echo	☐ Immunization Records	☐ Psychological Consult	☐ Radiology Reports	_____
☐ Eye Notes	☐ Laboratory Reports	☐ Psychological Report	☐ Billing Information	_____

7. Release via: ☐ Patient pick up ☐ Mail ☐ Fax ☐ Other _____

8. I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that Mayo Clinic Health System has already taken action in reliance on it. Revocation must be made in writing to: Mayo Clinic Health System, Release of Information Dept, 404 Fountain St., Albert Lea, MN 56007 The provider/facility will not condition treatment on whether I sign the authorization. **I may be charged for copies in accordance with state law.** Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.

This consent will terminate in one year unless the person or organization to whom disclosure is authorized is a treating healthcare provider, or on _____ (Specific date less than one year)

9. ☐ **I authorize the release of medical information specified above that is created after the date of my signature for one (1) year.**

10. ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  ☐ **Legal Guardian or Conservator** ☐ **Health Care Agent (Health Care Power of Attorney)**
- **If the patient is 17 years of age or younger,** the patient's <u>parent</u> or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship. **By signing, I hereby state that my parental rights have not been revoked by a court of law.** ☐ **Parent** ☐ **Legal Guardian**

Signature *(Required)* Signature Required	**Date Signed** *(Required)* *(month DD, YYYY)*
Printed Name of Person Signing *(If Not Patient)*	

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