



Release of Information Instructions

Authorization Completion Instructions

To protect the privacy of our patients and to maintain the confidentiality of their personal information, we must obtain a valid, complete and legible authorization for release of medical records.

1. Patient:

- Name: *Print the full, legal name of the patient*
- Previous/Maiden Name: *Any previous legal names*
- Birth Date: *Month, Day and Year of birth*
- Mailing Address of Patient: *Street, City, State and Zip Code of Patient*
- Phone: *Patient's phone number/cell phone number*

2. Release Information From:

- Check the sites listed where you have received care and would like your records released from.
- If the provider authorized to release medical records is other than a Mayo Clinic Health System facility, check the Other box and complete the individual, facility or company name of the person or provider. Fill in their complete address. Include their phone number if known.

3. Release Information To:

- Print the name of the person or organization that is to receive the medical records along with their complete address, city, state and zip code. Please include their phone number if known or check the box of the correct Mayo Clinic Health System facility.

4. Purpose of Release:

- Check the appropriate box that best explains the purpose of the request.
- If the Other box is checked, please write the reason in the space provided.

5. Release Type:

- Check the appropriate box if copies, a verbal exchange or a review of the medical record is requested.

6. Information to be Released:

- Fill in the appropriate dates of service if known.
- If records are needed by a specific date, fill in the Date Information Needed By.
- Check the box next to the types of medical records requested.
- If the Other box is checked, please write the needed medical records in the space provided.

7. Release Via:

- Check preferred delivery method.

8. Expiration Date:

- This authorization will be valid for one year unless otherwise specified by a date written in this area. Do not write today's date as the expiration date or the request will not be able to be processed.

9. I Extend to Release Any or All Documents in the Upcoming Year:

- Check this box to authorize medical records that are created after the date of signature on this form to be released. If this box is not checked, we are only able to release medical records that were created on or before the date this authorization was signed.

10. Signature:

- The patient or legal representative must sign and date the authorization.
- Attach copies of legal documents outlining the representative's legal right to sign on the patient's behalf.

Return your completed authorization to the Release of Information Department.