Authorization to Release Protected Health Information

[redacted] SCANNED

Example Only

Mayo Clinic Number [redacted] 5·678 | Last [redacted] | [redacted] | Birth Date (Month DD, YYYY) June 29, 1861

Release Information From

☒ Mayo Clinic, 200 [redacted] Street SW, Rochester, [redacted] 55905
☐ Other (Specify facility, individual & address below, including phone/fax if known.)

Release Information To

☐ Ma[redacted] SW, [redacted] MI [redacted]
☒ Oth[redacted] ual & address below, including phone/fax if
118 [redacted] Main Street
Le Sueur, M[redacted]

Purpose of [redacted]se

☒ Treatment/Continued Care
☐ Application for Insurance
☐ Other [redacted]

Please mail these records to my home on CD.
(As patient, you can decide how you want to obtain them)

Information to be Released

Service Dates (From [redacted] 1914 To 10·30·1914 | Inf[redacted] Needed By (Optional)

[redacted] and [redacted] ☐ EKG's ☐ Laboratory Reports ☒ Hospita[redacted]
☐ Radiology Reports [redacted]
☒ Clinic Notes [redacted] Reports ☐ Radiology Images [redacted]
☐ Other [redacted]

[redacted] Records from [redacted]ons above that are marked with an "X" as available to me per [redacted] law 45.CFR 164.501

Example Only Purposes Only

I understand the information to be released may include rec[redacted]d to behavior and/or mental hea[redacted]are, alcohol and drug abuse treatment, [redacted]nd genetics. This authorization may be revoked [redacted] except to the extent that action [redacted] been taken in reliance upon it. [redacted] must be made in writing to [redacted] provider/facility [redacted]e information. The provider/faci[redacted]ill not condition treatmen[redacted] [redacted]horization. **I may be charged for copies in accordance with state law.** Information used or disclosed pursuant to this [redacted] [redacted]ubject to redisclosure by the recipient and may no longer be protected by federal law.

This authorization will expire one year from the date of signing unless I indicate an earlier date [redacted]

ATTENTION: This is a legal document. [redacted] 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 [redacted]** 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 parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:
  ☐ Parent ☐ Legal Guardian

Signature (Required)	Date Signed (Required) (Month DD, YYYY)
	11·14·1914
Printed Name of Person Signing (If Not Patient)	William Mayo
Mailing Address of Patient - Street	118 North Main St.
City: Le Sueur / State: MN / ZIP Code: 56058 / Phone: 504.123·[redacted]	