MAYO CLINIC

Authorization to Release Protected Health Information

TO BE SCANNED

Mayo Clinic Number	Name (First, Middle, Last)	Birth Date (Month DD, YYYY)
123-45-678	William James Mayo	June 29, 1861

Instructions: If **any** section is incomplete, this form may be invalid.

Release Information From

- [X] Mayo Clinic, 200 First Street SW, Rochester, MN 55905
- [ ] Other *(Specify facility/individual & address below, including phone/fax if known.)*

Release Information To

- [ ] Mayo Clinic, 200 First Street SW, Rochester, MN 55905 Attn:_____ Bldg._____ Rm._____
- [X] Other *(Specify facility/individual & address below, including phone/fax if known.)*

118 North Main Street
Le Sueur, MN 56058

Purpose of Release

- [X] Treatment/Continued Care
- [ ] Application for Insurance
- [ ] Other
- [X] Personal
- [ ] Disability Determination
- [ ] Legal Purposes
- [ ] Payment of Insurance Claim

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 (Optional) From 10-18-1914 To 10-30-1914

Information Needed By (Optional) ASAP

- [ ] History and Physical
- [ ] Immunization Records
- [X] Clinic Notes
- [ ] EKG's
- [ ] Pathology Reports
- [X] Operative Reports
- [ ] Laboratory Reports
- [ ] Radiology Reports
- [ ] Radiology Images
- [X] Hospital Notes
- [X] Hospital Discharge Summary
- [ ] Billing Information
- [ ] Other

All UNABSTRACTED Records from sections above that are marked with an "X" as available to me per Hippa law 45.CFR 164.501

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 action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. 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 authorization will expire one year from the date of signing unless I indicate an earlier date or event here:_____.

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:
  - [X] 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	State	ZIP Code	Phone
Le Sueur	MN	56058	504.123.4567

MC0072-01rev1012

Example Purposes Only

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