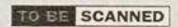
## MAYO CLINIC GD

## Authorization to Release Protected Health Information



23.45.678 William James Mayo			Birth Data (Month DD, 1777)		
Charles and the Control of the Contr	s incomplete, this form may be invalid	riayo	June 29, 1861		
elease Information		Release Inform	nation To		
(Mayo Clinic, 200 First Str	eet SW, Rochester, MN 55905	☐ Mayo Clinic, 200	First Street SW, Rochester, MN 55905	-	
Other (Specify facility/individual & address below, including phone/fax if known.)		x if Altri			
		ATMINANT I		OC IF	
		Le Sue	h Main Street	-	
ALTERNATE			56058		
			and the second second		
rpose of Release					
Treatment/Continued Car Application for Insurance Other	☐ Disability Determination	☐ Legal Purposes ☐ Payment of Insu			
Please me	uil these record	s to my have	00 00 00	-	
	( As patient you	can de cide L	ne on CD.	1	
formation to be R	eleased	CONT. CIC. CICK. T	NOW YOU MUNT TO DETAIN T	3000	
rvice Dates (Optional)		Informa	ion Needed By (Optional)	-	
CHICAGO TO CONTRACT OF THE PROPERTY OF THE PRO	- 1914 TO 10-30-1	1914 AS	tion Needed By (Optional)		
History and Physical Immunization Records	EKG's	☐ Laboratory Reports	Hospital Notes		
Clinic Notes		☐ Radiology Reports ☐ Radiology Images	Hospital Discharge Summary Billing Information		
Other	The Second Second				
ulth an "X"	as available to n	from section	ns above that are marked and 45.CFR 164.501	ed	
nderstand the information //AIDS, and genetics. This a vocation must be made in in the authorization. I may	to be released may include records re authorization may be revoked at any ti writing to the provider/facility releasin	stated to behavior and/or me time except to the extent that of the information. The provi- be with state law. Information	ntal health care, alcohol and drug abuse treatm action has been taken in reliance upon it, der/facility will not condition treatment on whe on used or disclosed pursuant to this authoriza	nent, ther I	
	one year from the date of signing unle		or event here:		
-			ou understand and accept the terms on this fo	orm.	
+ If the patient is 18	years of age or older, the patient mi	ust sign and date the form.			
If the patient is 18     Please indicate your	years of age or older and is incapa r legal authority and include document	ble of signing, a legally aut tation of your relationship	horized substitute may sign and date the form	1,	
		Care Agent (Health Care Pow	er of Attorney)	29	
• If the patient is 17	years of age or younger, the patient	's parent or legal guardian r	nust sign and date the form, unless an excepti	on	
Parent	r federal law. Please indicate your rela Legal Guardian	ationship:		488	
Signature (Required)		Date Sign	ed (Required) (Month pp, 1771)		
~~	- ~~		11-14-1914		
LEVISITED NISME OF PRISO	Signing (if Not Patient) William	iam Mayo			
Linner temper of Linner		In the selection			
Malling Address of Pati	ent - Street				
Mailing Address of Pati	ent-street North Main	St.			
Mailing Address of Pati	ent-Street Main eur	State ZIP Code	05% Phone 504.123.4567		