

# Authorization to Release Protected Health Information

SCANNED

Mayo Clinic Number 5-678	Birth Date (Month DD, YYYY) June 29, 1961
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<b>Information From</b> <input checked="" type="checkbox"/> Mayo Clinic, 200 Street SW, Rochester, MN 55905 <input type="checkbox"/> Other (Specify facility, individual & address below, including phone/fax if known.)	<b>Release Information To</b> <input type="checkbox"/> Mayo Clinic, 200 Street SW, Rochester, MN 55905 <input checked="" type="checkbox"/> Other (Specify facility, individual & address below, including phone/fax if known.) 118 North Main Street Le Sueur, MN
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**Purpose of Release**

☒ Treatment/Continued Care  
☐ Application for Insurance  
☐ Other

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 To) 1914 To 10-30-1914	Info Needed By (Optional) 11-14-1914
<input type="checkbox"/> EKG's <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Radiology Images	<input checked="" type="checkbox"/> Hospital Discharge Summary <input checked="" type="checkbox"/> Clinic Notes <input type="checkbox"/> Other

Records from [redacted] above that are marked with an "X" as available to me per 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, 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 this authorization. I may be charged for copies in accordance with state law. Information used or disclosed pursuant to this authorization is 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 [redacted]

**ATTENTION:** This is a legal document. 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 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) [Signature]	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]

Example

Only

Purposes Only

Example