



Authorization to Release Protected Health Information to a Third Party

Form content retained in medical record.
Route to HIM5 Scanning.

TO BE SCANNED

Instructions: This form is to be used by a patient or legal representative to authorize the release of information to a third party (other than a family member or friend) such as an insurance company, employer, or for legal purposes, etc. Print clearly; each section needs to be completed to be valid.

1. (complete fields or place patient label here)

Patient Name (First, Middle, Last)	
Birth Date (mm-dd-yyyy)	Room Number (if applicable)
Mayo Clinic Number	

Staff Use Only

<input type="checkbox"/> ROI to Send Records	<input type="checkbox"/> Scan to Chart
<input type="checkbox"/> Information Released by LAN ID	Date (mm-dd-yyyy)

2. Additional Patient Information

Previous or Maiden Name (if applies) (First, Middle, Last)	Daytime Phone	<input type="checkbox"/> Check this box if patient is deceased.
Patient Address (Street, City, State, ZIP Code)		

3. Release Purpose

Check appropriate box or write in other purpose.

Continuing care Disability Forms completion Insurance Legal Workers' compensation

Other, specify _____

4. Release Information FROM

Check one box and complete if applicable.

Mayo Clinic
Includes all Mayo Clinic and Mayo Clinic Health System locations

Other, specify organization, department, or individual (complete each line below)

Street _____

City _____

State _____ ZIP Code _____

Phone _____

Fax _____

5. Release/Send Information TO

Check one box and complete each line for box checked.

Mayo Clinic
Dept. _____ Attn. _____
Fax _____

Other, specify organization, department, or individual (complete each line below)

Street _____

City _____

State _____ ZIP Code _____

Phone _____

Fax _____

This authorization will expire in 1 year from date of signature *unless another date is specified:* _____

By checking this box I allow the ongoing exchange of information between the above parties until this authorization expires or is revoked.

By checking this box I also authorize the release of records for future visits or stays after the date of my signature until this authorization expires or is revoked.

6. Delivery of Information

Preferred Method <input type="checkbox"/> Written copy (may include completed forms) <input type="checkbox"/> Verbal only	Date Information Needed by (mm-dd-yyyy)
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Written information will be mailed unless an alternate method is checked.

Patient Portal – Mayo Clinic Patient Online Services

Fax (number listed above in section 5)

Email address _____

Pick-up at a Mayo Clinic location, specify _____

CD/DVD

USB flash/thumb drive

Other, specify _____

Authorization to Release Protected Health Information to a Third Party (continued)

(complete fields or place patient label here)

Patient Name (First, Middle, Last)
Birth Date (mm-dd-yyyy)
Mayo Clinic Number

7. Records or Reports to Be Released

Timeframe to Be Released		
Date(s) _____ or Year(s) _____ (mm-dd-yyyy) (yyyy)		
Document/Note(s) (check all that apply)		
<input type="checkbox"/> Behavioral health/Mental/Psychological notes	<input type="checkbox"/> Emergency department/Urgent care notes	
<input type="checkbox"/> Operative/Procedure notes	<input type="checkbox"/> Provider notes	
<input type="checkbox"/> Therapy notes (physical, occupational, speech)	<input type="checkbox"/> Other, specify _____	
I understand the information to be released may include behavior and/or mental health care, and HIV test results.		
Additional Records (check all that apply)		
<input type="checkbox"/> Allergy list	<input type="checkbox"/> Laboratory results	<input type="checkbox"/> Pathology report(s)
<input type="checkbox"/> Immunizations	<input type="checkbox"/> HIV lab test results	<input type="checkbox"/> EKG(s)/Cardio/Echo
<input type="checkbox"/> Medication list	<input type="checkbox"/> Genetic testing	<input type="checkbox"/> Radiology report(s)
<input type="checkbox"/> Billing information for records checked	<input type="checkbox"/> Radiology image(s), specify exam(s)/body part(s)	
Substance Abuse and Addiction Treatment Records (check all that apply)		
<input type="checkbox"/> Assessment/Evaluation	<input type="checkbox"/> Family participation invitation	<input type="checkbox"/> Treatment plans
<input type="checkbox"/> History and physical exam	<input type="checkbox"/> Questionnaires	<input type="checkbox"/> Other, specify _____
<input type="checkbox"/> Multidisciplinary notes	<input type="checkbox"/> Treatment/Discharge summary	
Other , specify if applicable _____		

8. Signature and Date The patient or legal representative must sign and date this authorization.

<ul style="list-style-type: none"> This authorization may be revoked at any time by providing a written notice of revocation to the Health Information Management Services (HIMS) Release of Information (ROI) department at the facility releasing the information, except to the extent that the Providers have already taken action in reliance on it. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law (42 CFR Part 2) (HIPAA). I understand that Mayo Clinic will not condition treatment on whether I sign this authorization. I may request a copy of the signed authorization. I may be charged for copies in accordance with state law. I have a right to inspect and receive a copy of the material to be disclosed. 	
Note: A patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require minor's authorization.	
Signature (required) ▶	Date (required) (mm-dd-yyyy)
Printed Name of Person Signing (if not patient) (First, Middle, Last)	
Relationship if Not Patient (legal documentation of the right of access by the signing individual may be required)	
<input type="checkbox"/> Parent <input type="checkbox"/> Stepparent <input type="checkbox"/> Legal guardian <input type="checkbox"/> Foster parent <input type="checkbox"/> Health care power of attorney/agent <input type="checkbox"/> Other _____	

HIMS* Release of Information Contact Information

Arizona 13400 East Shea Boulevard Scottsdale, AZ 85259 Phone 480-301-4211 Fax 480-301-7282	Florida 4500 San Pablo Road Jacksonville, FL 32224 Phone 904-953-2022 Fax 904-953-2242	Rochester 200 First Street SW Rochester, MN 55905 Phone 507-284-4594 Fax 507-284-0161	MCHS MN 1025 Marsh Street Mankato, MN 56001 Phone 507-594-2621 Fax 507-422-0902	MCHS WI 1400 Bellinger Street Eau Claire, WI 54703-5211 Phone 715-838-6395 Fax 715-838-3058
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Reminder: If sending records **TO** Mayo Clinic, fax records to number indicated in section 5 on page 1.

*Health Information Management Services