

Mayo Clinic Number



**TO BE SCANNED
AUTHORIZATION**

Patient Name

Authorization to Release Information **BY Mayo Clinic**

| | | |
|--|--|-----------------------|
| Purpose for Release of Information — | | Patient Date of Birth |
| <input type="checkbox"/> Evaluation <input type="checkbox"/> Treatment <input type="checkbox"/> Placement <input type="checkbox"/> Other _____ | | mm/dd/yyyy |
| Information Being Requested | | |

I, the undersigned, authorize Mayo Clinic Rochester to disclose any information (all protected health information), or the specific records (outlined above) — (including, but not limited to, information relating to psychiatric/psychologic, sickle cell anemia, and alcohol and drug diagnosis and treatment or information from its affiliated entities, if any such information exists) that it possesses regarding the patient named above being requested to the health care provider, person or institution as follows.

| | | | |
|--|-------|----------|------------------|
| Name of Health Care Provider, Person or Institution Requesting Information | | | |
| Mailing Address – Street | | | |
| City | State | Zip Code | Telephone Number |

As stated in Mayo Clinic's Notice of Privacy, this authorization may be revoked at any time except to the extent that Mayo has taken action in reliance upon this authorization. Revocation must be made in writing to the following appropriate entity: Mayo Clinic, Office of Patient Affairs, 200 First Street SW, Rochester, MN 55905.

Furthermore, I understand that Mayo Clinic will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization.

I understand that a copy of this authorization will be provided to me when Mayo Clinic receives the authorization.

I understand, that if this information is disclosed to a third party, the information may be redisclosed by the person or entity that receives the information and may no longer be protected by federal privacy regulations.

I also understand that I may be charged for copies of this information in accordance with state law.

| |
|---|
| Which ever is shorter, this authorization will terminate in one year or upon the following specified date or event. |
| Specified Date |
| mm/dd/yyyy |
| Or Specified Event |

| | | | |
|--------------------------|--|-------------------|------------------|
| Signature of Patient | Relationship to Patient (if Not Patient) | Date of Signature | |
| X | | mm/dd/yyyy | |
| Mailing Address – Street | | | |
| City | State | Zip Code | Telephone Number |

PATIENT INSTRUCTIONS: Please complete, sign and date this form where designated above and return Part 1 (original) as directed in attached correspondence (if any) or as instructed by Mayo Clinic staff. Please retain Part 2 for your records.

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