MAYO CLINIC

Authorization to Disclose Protected Health Information **BY** *Mayo Clinic*

Reset

Number (above) and Name

Note: Radiology and mammography films must be requested by calling Radiology Records at 480-301-8055.

Patient Name _____ Date of Birth _____

Address _____

Mayo Clinic Medical Record Number _____ Daytime Telephone Number _____

I hereby authorize Mayo Clinic Arizona ("Mayo Clinic") to disclose the following Protected Health Information pertaining to the above-referenced patient to:

Name of Person or Entity _____ ❑ Mail

Address _____ ❑ Pick-up

Date/Time

City, State, Zip Code _____

Purpose for release of information: ❑ Personal ❑ Continuing Patient Care ❑ Other _____

Information being requested, please specify (i.e., Physician/Provider/Service or Dates of Service or Records/Reports): _____

_____

_____

If above section is not completed, responses to records requests will contain a records abstract of two (2) most recent years from the last date of service. This will include:

- For hospital records - History and Physical, Discharge Summary, Operative/Procedure Reports, Emergency Department Report, Consultation Report and test results.
- For clinic records - Provider Notes, Operative/Procedure Reports and test results.

Billing statements needed: ❑ Yes

I understand this authorization covers records relating to communicable diseases, acquired immunodeficiency syndrome ("AIDS"), human immunodeficiency virus ("HIV"), behavioral and/or mental health care, alcohol and/or drug abuse treatment, and genetic testing, if any such records exist.

I understand that Mayo Clinic will not condition treatment on whether I sign this Authorization.

I understand that I have the right to revoke this authorization at any time except to the extent that Mayo Clinic has already taken action in reliance on it. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to: Mayo Clinic, Attention: Health Information Management Services, 13400 East Shea Boulevard, Scottsdale, Arizona 85259. I understand that the revocation will not apply to information that has already been released in response to this Authorization.

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

I understand that this authorization will expire one (1) year from the date of signing *unless* specified below:

Desired Expiration Date _____

Signature Required

Signature _____ Date _____

Print Name _____ Relationship to Patient (if not patient) _____

Office Use Only

Print

Any questions related to the release of information may be directed to Mayo Clinic Health Information Management Services at 480-301-8500.

MCS7602Rev0708