Please complete, print and submit. Reset Form

MAYO CLINIC

Patient Authorization for Electronic Health Care Information Access

(Mayo Clinic Number and Name Above)

Please note that any changes to this document will invalidate the Agreement

I, the undersigned, request and authorize Mayo Clinic and its staff to communicate with my authorized health care provider(s) involved in my care about any non-urgent aspect of my health and medical care by electronic means to include but not be limited to web browser correspondence and/or secure electronic mail. To facilitate this communication, a computer login to an SSL (Secure Socket Layer) web based server will be used. Access will be through a web browser using a secure channel provided by the web server. I also understand that my authorized healthcare provider will be able to communicate only with health care providers working at, or on behalf of Mayo Clinic. By giving this authorization I demonstrate an understanding of the following issues related to the use of web based electronic communications:

- Web based electronic communications are not appropriate for communication about all health issues, particularly those of an urgent nature and Mayo Clinic can make no guarantee of response within a certain timeframe. If you have an emergency medical condition, please contact your physician by phone and/or report to the nearest emergency department.
- Electronic communications outlined above are relatively secure but confidentiality cannot be guaranteed.
- Mayo Clinic cannot and does not guarantee that use of this means of communication will be free from technological difficulties including, but not limited to, loss of communication.
- Information related to medical care communicated by means of web based electronic communications may be incorporated and retained within the Mayo Clinic medical record. As a result, that information may be disseminated as part of an authorized release of a copy of the medical record.

I also agree to allow the following Referring Physician or Group Practice to receive, via electronic communications, copies of my medical records created or documented by Mayo Clinic health care providers. 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 information exists. I also understand that the Referring Physician or Group Practice listed below must also decide to participate in this electronic health information access program with the Mayo Clinic in order to receive my information and that Mayo Clinic cannot require referring Physicians or Practices to participate.

Physician Information

Referring Physician or Group Practice Name			
Mailing Address			
City	State	ZIP Code	Telephone Number

My signature below denotes that I accept the possible risk of loss of privacy of confidential information associated with communication by electronic means and nonetheless, agree to its use. I also agree that Mayo Clinic shall not be liable for any type of damage or liability arising from or associated with the use of this web based communications system.

This authorization for electronic communications is valid until I notify Mayo Clinic in writing that I no longer authorize the use of electronic means to communicate information concerning my medical care or otherwise revoke this authorization. Such revocation would not apply to any disclosures made in accordance with this authorization prior to the date of notification of revocation. Mayo Clinic also retains the right to terminate web-based access as a means of communication at any time if such use becomes, in its judgment, burdensome or inappropriate. I have had the opportunity to ask questions and resolve any concerns prior to my signing this authorization.

Patient Information

Patient, Parent, Guardian, or Authorized Representative Signature Signature Required			Birth Date *(Month DD, YYYY)*
Patient, Parent, Guardian, or Authorized Representative Printed Name	Relationship to Patient (if not patient)		Signature Date *(Month DD, YYYY)*
Mailing Address		Want records post-dated back to *(Month DD, YYYY)*	
City	State	ZIP Code	Telephone Number

Please fax this completed document to (904) 953-0759 or send original to:
Mayo Clinic
Attention: Referring Physician Office
4500 San Pablo Road
Jacksonville, FL 32224

Alternatively, you may also give this document to any Mayo Clinic Registration Desk.

MCS568204 EHPA

Attention Mayo Clinic Desk Personnel:
If patient presents this document, please fax to (904) 953-0759 and send the original via Intra-Clinic Mail to the Referring Physician Office, 4500 San Pablo Road, Jacksonville, FL 32224

Part 1 - Referring Physician Office Copy **Part 2 - Patient Copy**

Print