Authorization to Disclose Protected Health Information BY Mayo Clinic

Number (above) and Name

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 ______________________

Address ______________________

City, State, Zip Code ______________________

❑ Mail
❑ Pick-up at
❑ Clinic (E. Shea Blvd)
❑ Hospital (56th/Mayo Blvd)
❑ Date/Time ____________

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): ____________

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If above section is not completed, responses to records requests will contain a record abstract of the most recent notes and results. This will include:

- For hospital records - History and Physical, Discharge Summary, Operative/Procedure Reports, Emergency Department Report, Consultation Report and test results.
- For clinic/outpatient records - Physician or midlevel provider visit notes, Operative/Procedure Reports and test results.

Billing statements needed: ❑ Yes

Note: For Radiology Imaging and Mammogram films please call 480-301-8055 for assistance.

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 Date

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

Any questions related to the release of information may be directed to Mayo Clinic Health Information Management Services at 480-301-4211.

Office Use Only

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