Complete and print.

Reset Form

MAYO CLINIC

Authorization to Release Substance Abuse and Addiction Treatment Information

(complete fields or place patient label here)

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

TO BE SCANNED BACKUP

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

Outage Date _____ *(mm-dd-yyyy)* Outage Time _____ *(hh:mm 24-hour clock)*

I authorize the Substance Abuse and Addiction Treatment programs at Mayo Clinic to disclose to and receive information from the below insurer related to my substance abuse and addiction treatment for purposes of receiving payment for health care services and the insurer's health care operations.

Patient Information

Street Address		Phone
City	State	ZIP Code

Insurance Information

Insurer Name		Plan Number
Street Address		Phone
City	State	ZIP Code

I authorize the above-referenced Substance Abuse and Addiction Treatment program to exchange or share my medical information* with Mayo Clinic who will further share the information among and between my past, current and future medical providers for claim resolution, treatment purposes, care coordination, scheduling and other health care operations which includes but is not limited to, affiliated care providers located at the following Mayo Clinic locations: Mayo Clinic: Arizona, Florida, Rochester; Mayo Clinic Hospital — Rochester; Mayo Clinic Health System: Decorah Clinic physicians, Fairmont, Lake City, Southeast Minnesota Region, Southwest Minnesota Region, St. James, Franciscan Healthcare, Inc., Franciscan Medical Center, Inc., Northwest Wisconsin Region, Inc., Pharmacy and Home Medical, Inc.; Charterhouse, Inc.; Gold Cross Ambulance Service; John E. Herman Home; Mayo Foundation for Medical Education and Research; Bloomer Lakeview, Inc.; Health Tradition Health Plan; Mayo Clinic Support Services, Texas.

* Medical Information: including but not limited to, information related to medical, mental health, HIV/AIDS and substance abuse and addiction diagnosis and treatment records, if any such information exists.

I authorize disclosure of the following information related to my substance abuse and addiction treatment.

☐ All Available Information	☐ History and Physical Exam	☐ Progress Notes
☐ Assessment/Evaluation	☐ Lab Results	☐ Treatment/Discharge Summary
☐ Family Questionnaire	☐ Multidisciplinary Progress Reports/Notes	☐ Treatment Plans
☐ Family Participation Invitation	☐ Mental Health Reports/Notes	☐ X-Ray Report(s)
■ Other (Specify) Chart if applicable		

AODARO

ENTERPRISE: Applies to Mayo Clinic locations in Arizona, Florida, Rochester and Mayo Clinic Health System.

Authorization to Release Substance Abuse and Addiction Treatment Information (continued)

(complete fields or place patient label here)

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

Patient Restrictions on Methods for Disclosure

- I understand that communication of the items to be obtained or disclosed can occur:
  - Verbally
  - Pick up
  - In-person conference
  - Written questionnaire
  - Mailed medical/correspondence
  - E-mailed medical/correspondence
  - Faxed medical/correspondence
- I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent expires automatically two years from the date I sign it or upon specified date or event:

Consent Expiration Date *(mm-dd-yyyy)* or Event Name

  Revocation must be made in writing to: Mayo Clinic, Release of Information., 200 First Street SW, Rochester, MN 55905.
- I understand that Federal confidentiality regulations (42 CFR Part 2) generally prohibit re-disclosure of information from alcohol and drug abuse patient records without your further consent.
- I understand I have the right to obtain a list of the individuals and/or entities that my information has been disclosed to. I must submit this request in writing to Mayo Clinic, Release of Information., 200 First Street SW, Rochester, MN 55905. The facility must respond to the request within 30 days of receiving the request. I must specify the time frame, up to two years, for which I would like a list of disclosures.

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

Signature (required) Signature Required	Date (required) *(mm-dd-yyyy)*
Printed Name of Person Signing (if not patient) *(First, Middle, Last)*	
Parent or Guardian Signature (for SAAT records only) Signature Required	Note: Substance Abuse and Addiction Treatment (SAAT) records require minor **and** parent or guardian signatures.
Relationship if Not Patient *(Legal documentation of the right of access by the signing individual may be required.)* ☐ Parent ☐ Stepparent ☐ Legal guardian ☐ Foster parent ☐ Health care power of attorney/agent** ☐ Other_____ **Must be activated for states of Arizona and Wisconsin.	

Print