MAYO CLINIC

Authorization to Release Protected Health Information

Mayo Clinic Blood Donor Program

This form collects information that is not part of the medical record.
For local storage only.

(Donor ID and Date of Birth Above)

Instructions: Complete **all** sections. If **any** section is incomplete, this form may be invalid.

Mayo Clinic Number	Name *(First, Middle, Last)*	Birth Date *(Month DD, YYYY)*

Release Information From

☒ Mayo Clinic, 200 First Street SW, Rochester, MN 55905
☒ Mayo Clinic Blood Donor Center

Release Information To

☒ Mayo Clinic Blood Donor Center
☒ Mayo Clinic, 200 First Street SW, Rochester, MN 55905

Purpose of Release

This authorization will be used as necessary to facilitate the blood donation process which may include the need to screen for donor eligibility, report and document adverse reactions, report and document donation related blood testing results, obtain contact information, and perform quality assurance reviews.

Information to be Released

I authorize the release of my medical record documentation to the Mayo Clinic Blood Donor Center solely for the purpose stated above. I understand that this release will allow the Mayo Clinic Blood Donor staff to access my medical record via hard copy or on-line (electronically) via my electronic health record (EHR).

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the Mayo Clinic Blood Donor Center. Mayo Clinic will not condition treatment on whether I sign the authorization. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.

This authorization will expire upon revocation.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the donor is 18 years of age or older,** the donor must sign and date the form.
- **If the donor is 18 years of age or older and is incapable of signing,** a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  ☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)
- **If the donor is 17 years of age or younger,** the donor's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:
  ☐ Parent ☐ Legal Guardian

Signature *(Required)*	**Date Signed** *(Required)* *(Month DD, YYYY)*

Printed Name of Person Signing *(If Not Donor)*			
Mailing Address of Donor - Street			
City	State	ZIP Code	Phone