Complete and print.

Reset Form

MAYO CLINIC

Authorization to Disclose Protected Health Information to Family and Friends

Adult Patient

TO BE SCANNED

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

(complete fields or place patient label here)

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

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

Your privacy is important to us and we want to protect it as much as possible. By signing this form, you authorize Mayo Clinic to disclose information as requested to the individual you list below.

Release Information To

Person Authorized to Receive Information (list one individual per form)	Name *(First, Middle, Last)*	Birth Date *(mm-dd-yyyy)*

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Child ☐ Sibling ☐ Other:

The individual named above is authorized to obtain information in the following manner(s) (check all that apply):

- ☐ Verbally: for example, via phone, face-to-face.
- ☐ Patient Online Services: when the above-named individual submits a proxy request form through Patient Online Services, this access will be enabled.
- ☐ Written or printed format: for example, medical record copies or the patient appointment guide.
- ☐ Mayo Clinic's electronic medical record systems: if the above-named individual is a Mayo Clinic staff member with permissions to access the electronic health record, the individual can view your protected health information electronically.

I understand the information to be released may include my past, present, or future health information including billing, treatment, records related to behavior and 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 provider or facility releasing the information.

The provider or facility will not condition treatment on whether I sign the authorization. **I may be charged for copies in accordance with state law.** Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law. The patient has a right to inspect and receive a copy of the material disclosed. This authorization will not affect any previous authorizations that I have signed. If I want to change any previous authorizations, I must submit a request in writing to have any previous authorizations revoked.

This authorization will not expire unless revoked by you or your legal representative or upon notification of death.

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

- **This form is for patients 18 years of age or older.** The patient must sign and date this form.
- **If the patient 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)

Signature (required) ▶ Signature Required	Date (required) *(mm-dd-yyyy)*
Printed Name of Person Signing (if not patient) *(First, Middle, Last)*	
Patient Street Address	

City	State	ZIP Code	Phone

Send your form to:

HIMS Release of Information
200 First Street SW
Rochester, MN 55905

Fax 507-284-0161
Email mayohimsroi@mayo.edu

Print

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