



Authorization to Disclose Protected Health Information to Family and Friends Minor Child



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		
<p>The individual named above is authorized to obtain information in the following manner(s) (check all that apply):</p> <input type="checkbox"/> Verbally: for example, via phone, face-to-face. <input type="checkbox"/> Patient Online Services: when the above-named individual submits a proxy request form through Patient Online Services, this access will be enabled. <input type="checkbox"/> Written or printed format: for example, medical record copies or the patient appointment guide.		

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 expire in one year or upon the child's 18th birthday or upon notification of death.

<p>Attention: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.</p> <ul style="list-style-type: none"> This form is for patients 17 years of age or younger. The patient's parent or legal guardian must sign and date this form, unless an exception exists under state or federal law. <p>Please indicate relationship:</p> <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian			
Signature (required)		Date (required) (mm-dd-yyyy)	
Printed Name of Person Signing (First, Middle, Last)			
Patient Street Address			
City	State	ZIP Code	Phone

Send your form to:

HIMS Release of Information Fax 507-284-0161
 200 First Street SW Email mayohimsroi@mayo.edu
 Rochester, MN 55905

