



Authorization To Disclose Protected Health Information

Health Information Management Services
Campus Support Center
4500 San Pablo Road
Jacksonville, Florida 32224
(904) 953-2022
Return Fax (904) 953-2242

PLEASE PRINT

RELEASE INFORMATION FROM <input type="checkbox"/> Mayo Clinic in Florida (MCF) <input type="checkbox"/> Other Mayo Site (Please Specify) <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other (Specify Facility/Address) 	DISCLOSE INFORMATION TO <input type="checkbox"/> MCF Health Information Management Services <input type="checkbox"/> Other (Specify Facility/Individual/Address/Relationship, as applicable)
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PURPOSE OF DISCLOSURE

Continued Care (abstract* will be provided, unless otherwise specified)

Personal - **I understand that** I may be charged for copies of this information in accordance with applicable state law.

Other _____

INFORMATION TO BE DISCLOSED (Specify service dates _____)

HOSPITAL Abstract (includes, as applicable, Discharge Summary, Discharge Medication List, History & Physical, Operative/Procedure Report(s), ED Report(s), Consultation Report(s), and test result(s))

CLINIC Abstract (includes, as applicable, most recent Return Visit, History & Physical, Consultation Report(s), Summary Lists, and test result(s))

Other _____

IDENTIFYING INFORMATION AT THE TIME OF SERVICE

Patient's Full Name

Medical Record Number/Last 4 digits of Patient's Social Security Number

Address

Patient's Date of Birth

City/State/Zip

Patient's Phone Number

I understand that disclosure of the information in this medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information relating to behavioral or mental health services or treatment, treatment for substance abuse, or genetic test results.

I understand that this authorization will expire in one year from the date signed unless otherwise specified: _____.

I understand that once the information is disclosed, the information is subject to redisclosure and may no longer be protected by the federal privacy regulations. This form may be revoked at any time providing the information has not already been disclosed. I may revoke this authorization by notifying, in writing, the Health Information Management Supervisor, 4500 San Pablo Road, Campus Support Center, Jacksonville, FL 32224.

I understand that Mayo will not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization.

I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.


_____ My initials on this line indicate I am authorizing the person(s) listed in the "Disclose Information To" box above to access access to my Patient Portal upon request by that person. I understand that my authorization grants this person access to my past, present and future protected health information. Access to my Patient Portal will not expire until such time that I revoke access in writing.

X _____
*Signature of Patient or Patient's Representative**

Relationship (if not patient)

Date

*If a personal representative of the patient signs the authorization, please indicate his or her authority to act.

Official Use Only				
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Log # _____				

Release of Medical Records

A record of the care you received is retained in Health Information Management Services. Medical records are kept in strict confidence and are not released without the written authorization of the patient except as permitted or required by law. Please call Mayo Clinic Health Information Management Services at (904) 953-2022 to obtain a copy of your medical information. In accordance with Florida law, the charge for patients to obtain medical records is as follows:*

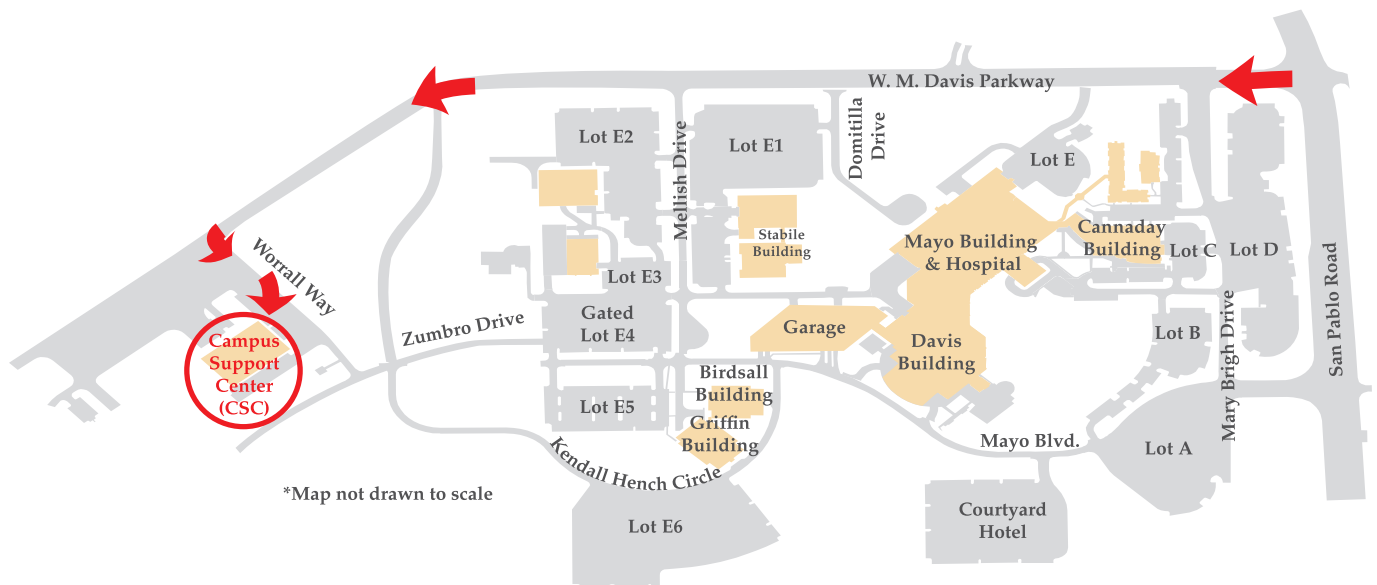
CLINIC - \$1.00 per page up to 25 pages and 15 cents for each additional page, plus postage.

HOSPITAL - \$1.00 per year search fee and then \$1.00 per page plus postage.

This fee is waived if information is disclosed for continuing care.

*The charge to obtain medical information from other Mayo sites is in accordance with appropriate state laws.

For your convenience, we prefer to mail your information. However, you can arrange to pick up your records at the Mayo Campus Support Center (map below). Please allow 24-48 hours to process your request.



Directions to Health Information Management Services

(located at the Mayo Campus Support Center)

- From San Pablo Road, take Davis Parkway (second light north of Butler Boulevard).
- Go 0.8 miles (past forested area, road will bend to the left).
- Turn left on Worrall Way.
- Campus Support Center is a large white building on the right.
- Turn into the parking lot located on the east side of the building and park in one of the spaces designated for "Medical Records Pick-Up."
- Parking is located directly in front of the "Medical Records Pick-Up" area.