Reset

MAYO CLINIC

Authorization to Disclose Protected Health Information **BY** *Mayo Clinic*

Number (above) and Name

Patient Name ______________________ Date of Birth ______________________
Address ______________________
Mayo Clinic Medical Record Number ______________________ Daytime Telephone Number ______________________

I hereby authorize Mayo Clinic Arizona ("Mayo Clinic") to disclose the following Protected Health Information pertaining to the above-referenced patient to:

Name of Person or Entity ______________________
Address ______________________
City, State, Zip Code ______________________

☐ Mail*
☐ Pick-up at*
☐ Clinic (E. Shea Blvd)
☐ Hospital (56th/Mayo Blvd)
☐ Date/Time ______________________

For Medical Records

Purpose for release of information: ☐ Personal ☐ Continuing Patient Care ☐ Other ______________________
*Charges may apply for copies delivered directly to the patient.

Information being requested, please specify (i.e., Physician/Provider/Service or Dates of Service or Records/Reports) **(for images, see below)**:

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If above section is not completed, responses to records requests will contain a record abstract of the most recent notes and results. This will include:

- For hospital records - History and Physical, Discharge Summary, Operative/Procedure Reports, Emergency Department Report, Consultation Report and test results.
- For clinic/outpatient records - Physician or midlevel provider visit notes, Operative/Procedure Reports and test results.

Billing statements needed: ☐ Yes

For Images/Films

☐ Mail*
☐ Pick-up at*
☐ Clinic (E. Shea Blvd)
☐ Hospital (56th/Mayo Blvd)

Radiology Records needed (includes radiology report and image in electronic format): ☐ Date/Time ______________________

Exam Date	Exam Description	Exam Date	Exam Description

I understand this authorization covers records relating to communicable diseases, acquired immunodeficiency syndrome ("AIDS"), human immunodeficiency virus ("HIV"), behavioral and/or mental health care, alcohol and/or drug abuse treatment, and genetic testing, if any such records exist.

I understand that Mayo Clinic will not condition treatment on whether I sign this Authorization.

I understand that I have the right to revoke this authorization at any time except to the extent that Mayo Clinic has already taken action in reliance on it. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the mail address below. I understand that the revocation will not apply to information that has already been released in response to this Authorization.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or entity that receives the information.

I understand that this authorization will expire one (1) year from the date of signing unless specified below:

Desired Expiration Date ______________________

Print below & Sign.

______________________ Signature ______________________ Date

______________________ Print Name ______________________ Relationship to Patient (if not patient)

Mayo Clinic
Attention: Health Information Management Services
13400 East Shea Blvd.
Scottsdale, AZ 85259

Any questions related to the release of information may be directed to Mayo Clinic Health Information Management Services at 480-301-4211 or Radiology Records at 480-301-8055.

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