Complete and print.

Reset Form

MAYO CLINIC

Authorization to Release Protected Health Information to a Third Party

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

TO BE SCANNED

Instructions: This form is to be used by a patient or legal representative to authorize the release of information to a third party (other than a family member or friend) such as an insurance company, employer, or for legal purposes, etc. Print clearly; each section needs to be completed to be valid.

1. *(complete fields or place patient label here)*

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

Staff Use Only

☐ ROI to Send Records ☐ Scan to Chart	
☐ Information Released by LAN ID	Date *(mm-dd-yyyy)*

2. Additional Patient Information

Previous or Maiden Name (if applies) *(First, Middle, Last)*	Daytime Phone	☐ Check this box if patient is deceased.
Patient Address *(Street, City, State, ZIP Code)*		

3. Release Purpose

Check appropriate box or write in other purpose.

☐ Continuing care ☐ Disability ☐ Forms completion ☐ Insurance ■ Legal ☐ Workers' compensation

☐ Other, specify _____

4. Release Information FROM

Check one box and complete if applicable.

☐ **Mayo Clinic**
Includes all Mayo Clinic and Mayo Clinic Health System locations

☐ **Other,** specify organization, department, or individual (complete each line below)

_____

Street _____

City _____

State _____ ZIP Code _____

Phone _____

Fax _____

5. Release/Send Information TO

Check one box and complete each line for box checked.

☐ **Mayo Clinic**

Dept. _____ Attn. _____

Fax _____

■ **Other,** specify organization, department, or individual (complete each line below)

Legal-Ease Digital Imaging LLC

Street 2496 Meadowcroft Dr

City Burton

State MI ZIP Code 48519

Phone 855-543-4003

Fax 810-547-4030

This authorization will expire in 1 year from date of signature *unless another date is specified:* _____

☐ **By checking this box** I allow the ongoing exchange of information between the above parties until this authorization expires or is revoked.

☐ **By checking this box** I also authorize the release of records for future visits or stays after the date of my signature until this authorization expires or is revoked.

6. Delivery of Information

Preferred Method ☐ Written copy (may include completed forms) ☐ Verbal only	Date Information Needed by *(mm-dd-yyyy)*

Written information will be mailed unless an alternate method is checked.

☐ Patient Portal – Mayo Clinic Patient Online Services

■ Fax (number listed above in section 5)

■ Email address pat.legalease@gmail.com

☐ Pick-up at a Mayo Clinic location, specify _____

■ CD/DVD

☐ USB flash/thumb drive

☐ Other, specify _____

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

©2019 Mayo Foundation for Medical Education and Research

Next Page

Authorization to Release Protected Health Information to a Third Party (continued)

(complete fields or place patient label here)

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

7. Records or Reports to Be Released

Timeframe to Be Released

Date(s)_____ or Year(s)_____
(mm-dd-yyyy) *(yyyy)*

Document/Note(s) (check all that apply)

- ☐ Behavioral health/Mental/Psychological notes
- ☐ Emergency department/Urgent care notes
- ☐ Operative/Procedure notes
- ☐ Provider notes
- ☐ Therapy notes (physical, occupational, speech)
- ☐ Other, specify _____

I understand the information to be released may include behavior and/or mental health care, and HIV test results.

Additional Records (check all that apply)

- ☐ Allergy list
- ☐ Immunizations
- ☐ Medication list
- ☐ Laboratory results
- ☐ HIV lab test results
- ☐ Genetic testing
- ☐ Pathology report(s)
- ☐ EKG(s)/Cardio/Echo
- ☐ Radiology report(s)
- ☐ Radiology image(s), specify exam(s)/body part(s)
- ☐ Billing information for records checked

Substance Abuse and Addiction Treatment Records (check all that apply)

- ☐ Assessment/Evaluation
- ☐ History and physical exam
- ☐ Multidisciplinary notes
- ☐ Family participation invitation
- ☐ Questionnaires
- ☐ Treatment/Discharge summary
- ☐ Treatment plans
- ☐ Other, specify_____

Other, specify if applicable _____

8. Signature and Date The patient or legal representative must sign and date this authorization.

- This authorization may be revoked at any time by providing a written notice of revocation to the Health Information Management Services (HIMS) Release of Information (ROI) department at the facility releasing the information, except to the extent that the Providers have already taken action in reliance on it.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law (42 CFR Part 2) (HIPAA).
- I understand that Mayo Clinic will not condition treatment on whether I sign this authorization.
- I may request a copy of the signed authorization.
- I may be charged for copies in accordance with state law.
- I have a right to inspect and receive a copy of the material to be disclosed.

Note: A patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require minor's authorization.

Signature (required) ▶ Signature Required	**Date** (required) *(mm-dd-yyyy)*

Printed Name of Person Signing **(if not patient)** *(First, Middle, Last)*

Relationship if Not Patient (legal documentation of the right of access by the signing individual may be required)

☐ Parent ☐ Stepparent ☐ Legal guardian ☐ Foster parent ☐ Health care power of attorney/agent ☐ Other_____

HIMS* Release of Information Contact Information

Arizona	**Florida**	**Rochester**	**MCHS MN**	**MCHS WI**
13400 East Shea Boulevard	4500 San Pablo Road	200 First Street SW	1025 Marsh Street	1400 Bellinger Street
Scottsdale, AZ 85259	Jacksonville, FL 32224	Rochester, MN 55905	Mankato, MN 56001	Eau Claire, WI 54703-5211
Phone 480-301-4211	Phone 904-953-2022	Phone 507-284-4594	Phone 507-594-2621	Phone 715-838-6395
Fax 480-301-7282	Fax 904-953-2242	Fax 507-284-0161	Fax 507-422-0902	Fax 715-838-3058

Reminder: If sending records **TO** Mayo Clinic, fax records to number indicated in section 5 on page 1.

*Health Information Management Services

Print

MC0072-01rev0419