FOUNTAIN CENTERS

A Mayo Clinic Health System program for substance abuse and addiction

Authorization for Release of Information

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Patient Information

Patient Name *(First, Middle, Last)*	Medical Record Number	Birth Date *(Month, DD, YYYY)*
Address *(Street)*		Phone Number
City	State	ZIP Code

I, authorize _____

to disclose to and receive information from:

Name of Individual & Organization Name if Applicable		
Address *(Street)*		Phone Number
City	State	ZIP Code

The following information relates to my treatment for chemical dependency.

- ☐ Treatment/Discharge Summary
- ☐ Assessment/Evaluation
- ☐ Progress Notes
- ☐ Lab Results
- ☐ Treatment Plans
- ☐ Other (Specify) _____
- ☐ Multidisciplinary Progress Reports/Notes
- ☐ Mental Health Reports/Notes
- ☐ History and Physical Exam
- ☐ Family Questionnaire
- ☐ Family Participation Invitation
- ☐ X-Ray Report(s)

The information is needed for the following purpose(s): _____

Dated needed by: _____

Patient Restrictions on Methods for Disclosure:

I understand that communication of the items to be obtained or disclosed can occur:

- ☐ Verbally
- ☐ Pick up
- ☐ In-person conference
- ☐ Mailed medical/correspondence
- ☐ Faxed medical/correspondence
- ☐ Written questionnaire
- ☐ E-mailed medical/correspondence

- I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.), and that in any event this consent expires automatically in one year from the date I sign it or upon specified date or event: _____ Revocation must be made in writing to: Mayo Clinic Health System, Release of Information Dept., 404 Fountain St., Albert Lea, MN 56007
- I understand that Federal confidentiality regulations (42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient records. However, HIPAA requires Fountain Centers to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA rules.
- I understand that Fountain Centers will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization.

Date	Signature of Patient
Sent	Signature of Witness
By	Signature of Parent/Guardian When Necessary and Relationship to Patient