MAYO CLINIC HEALTH SYSTEM

Lake City and Wabasha

Authorization to Release Protected Health Information

Instructions: All sections need to be completed to be a valid authorization.

1. Legal Name *(Last, First, Middle)*	Previous Name		Medical Record Number
Address *(Street)*	Phone Number		Cell Phone Number
City	State	ZIP Code	Birth Date

2. Release Information From

Mayo Clinic Health System
Attn: _____

☐ 500 West Grant Street, Lake City, MN 55041
Fax: 651-345-1151

☐ 1202 Fifth Grant Blvd. West, Wabasha, MN 55981
Fax: 651-565-4148

☐ Other *(Specify facility/dept/individual & address below, including phone/fax if known.)*

_____
_____
_____
_____

3. Release Information To

Mayo Clinic Health System
Attn: Release of Information

☐ 500 West Grant Street, Lake City, MN 55041
Phone: 651-345-3321 ext. 57472 Fax: 651-345-1151

☐ 1202 Fifth Grant Blvd. West, Wabasha, MN 55981
Phone: 651-565-5931 Fax: 651-565-4818

☐ Other *(Specify facility/dept/individual & address below, including phone/fax if known.)*

_____
_____
_____
_____

4. Purpose of Release

☐ Treatment/Continued Care ☐ Personal ☐ Legal Purposes ☐ Transfer of Care
☐ Application for Insurance ☐ Disability Determination ☐ Payment of Insurance Claim ☐ No Records Needed at this Time - Keep on File
☐ Other _____

5. Release type: ☐ Verbal (no copies) ☐ Hard Copy ☐ Review of record (no copies)

6. Information to be Released

Service Dates (Optional) **From** **To**

Date Information Needed By

☐ 2 Year History ☐ Forms ☐ Medications/Allergies ☐ Psychological Testing ☐ Other _____
☐ Clinic Notes ☐ Hospital Notes ☐ Phys/Occ/Sp Therapy ☐ Radiology Images _____
☐ EKG's/Cardio/Echo ☐ Immunization Records ☐ Psychological Consult ☐ Radiology Reports _____
☐ Eye Notes ☐ Laboratory Reports ☐ Psychological Report ☐ Billing Information _____

7. Release via: ☐ Patient pick up ☐ Mail ☐ Fax ☐ Other _____

8. I understand the information to be released may include records related to behavior and/or 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 Mayo Clinic Health System has already taken action in reliance on it. Revocation must be made in writing to: Mayo Clinic Health System, Release of Information Dept, 404 Fountain St., Albert Lea, MN 56007 The provider/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 redisclosure by the recipient and may no longer be protected by federal law.

This consent will terminate in one year unless the person or organization to whom disclosure is authorized is a treating healthcare provider, or on _____ (Specific date less than one year)

9. ☐ **I authorize the release of medical information specified above that is created after the date of my signature for one (1) year.**

10. ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  ☐ **Legal Guardian or Conservator** ☐ **Health Care Agent (Health Care Power of Attorney)**
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship. **By signing, I hereby state that my parental rights have not been revoked by a court of law.** ☐ **Parent** ☐ **Legal Guardian**

Signature *(Required)*	**Date Signed** *(Required)* *(month DD, YYYY)*
Printed Name of Person Signing *(If Not Patient)*	

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MAYO CLINIC HEALTH SYSTEM

Release of Information Instructions

Authorization Completion Instructions

To protect the privacy of our patients and to maintain the confidentiality of their personal health information, we must obtain a valid, complete and legible authorization for release of medical records.

1. **Patient:**
   - Name: *Print the full, legal name of the patient*
   - Previous/Maiden Name: *Any previous legal names*
   - Birth Date: *Month, Day and Year of birth*
   - Mailing Address of Patient: *Street, City, State, and Zip Code of Patient*
   - Phone: *Patient's phone number / cell phone number*
2. **Release Information From:**
   - Check the sites listed where you have received care and would like your records released from.
   - If the provider authorized to release medical records is other than a Mayo Clinic Health System facility, check the Other box and complete the individual, Facility or Company Name of the person or Provider. Fill in their complete address. Include their phone number if known.
3. **Release Information To:**
   - Print the name of the person or organization that is to receive the medical records along with their complete address, city, state, and zip code. Please include their phone number if known or check the box of the correct MCHS Facility.
4. **Purpose of Release:**
   - Check the appropriate box that best explains the purpose of the request.
   - If the Other box is checked, please write the reason in the space provided.
5. **Release Type:**
   - Check the appropriate box if copies, a verbal exchange, or a review of the medical record is requested.
6. **Information to be Released:**
   - Fill in the approximate dates of service if know.
   - If records are needed by a specific date, fill in the Date Information Needed By.
   - Check the box next to the types of medical records requested.
   - If the Other box is checked, please write the needed medical records in the space provided.
7. **Release Via:**
   - Check preferred delivery method.
8. **Expiration Date:**
   - This authorization will be valid for one year unless otherwise specified by a date written in this area. Do not write today's date as the expiration date or the request will not be able to be processed.
9. **I extend to release any or all documents in the upcoming year:**
   - Check this box to authorize medical records that are created after the date of signature on this form to be released. If this box is not check, we are only able to release medical records that were created on or before the date this authorization was signed.
10. **Signature:**
    - The patient or legal representative must sign and date the authorization.
    - Attach copies of legal documents outlining the representative's legal right to sign on the patient's behalf.

Return your completed authorization to the Release of Information Department.