MAYO CLINIC

Authorization to Disclose Protected Health Information by Mayo Clinic

Patient Name _____ Date of Birth _____

Address _____

Mayo Clinic Medical RecordNumber _____ Daytime Telephone Number _____

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

❑ Abstract*

*Abstract includes: For hospital records - History & Physical, Discharge Summary, Operative/Procedure Reports, Emergency Department Report, Consultation Report and all test results. For clinic records - General Medical Exams, Subsequent Visit Notes, Consultation Reports, Operative/Procedure Reports and all test results. Abstracts are prepared for the two most recent years.

Specify physician/provider names and dates/date ranges, when known:

_____

❑ Discharge Summary
❑ History & Physical
❑ Daily Progress Notes
❑ Physician Orders
❑ Consultation Reports
❑ Emergency Dept. Reports
❑ Clinic Visit Notes
❑ X-ray/Imaging Reports
❑ Laboratory Report
❑ Pathology Reports
❑ Radiology Imaging Films
❑ Pathology Slides
❑ Billing Statement
❑ Other: _____

_____

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 information exists.

Such records shall be disclosed to: ExamOne
800 NW Chipman Rd. / Suite 5900
POBox 2340
Lee's Summit, MO 64063-1149

This information will be disclosed for the following purpose(s): _____

_____

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: Mayo Clinic, Attention: Medical Records Department, 13400 East Shea Boulevard, Scottsdale, Arizona 85259. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that this authorization will expire one year from the date of signing unless otherwise specified: _____

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.

_____ _____
Signature **Date**

_____ _____
Print Name **Relationship to Patient (if not patient)**

Any questions related to the release of information may be directed to the Mayo Clinic Medical Records Department at 480-301-8500.