MAYO CLINIC
Jacksonville, Florida

Mayo Clinic
4500 San Pablo Road
Jacksonville, Florida 32224

St. Luke's Hospital
4201 Belfort Road
Jacksonville, Florida 32216

Authorization To Disclose Protected Health Information

PLEASE PRINT

RELEASE INFORMATION FROM:

☐ Mayo Clinic (MCJ)
☐ St. Luke's Hospital (SLH)
☐ Pharmacy

☐ Other (Specify Name/Facility and Address):

ExamOne
800 NW Chipman Rd. / Suite 5900
☐ POBox 2340
Lee's Summit, MO 64063-1149

SEND INFORMATION TO:

☐ MCJ/ATTN:_____
☐ SLH

PURPOSE OF DISCLOSURE: ☐ Continued Care ☐ Personal ☐ Other: _____

INFORMATION TO BE DISCLOSED: (Specify exact service dates:_____)

☐ Discharge Summary	☐ Emergency Report	☐ Laboratory Result(s)	☐ Abstract*
☐ History and Physical	☐ Consultation Report	☐ Radiology Report(s)	☐ Entire medical record
☐ Operative/Procedure Report	☐ Pathology Report(s)	☐ EKG Results	☐ Echo Tapes
☐ Psychiatry/Psychology Documentation	☐ Billing statement	☐ X-ray(s) films	☐ Cath CDs
	☐ Medication List	☐ Pathology Materials	☐ Other: _____

** Abstract includes, as applicable: At SLH - Discharge Summary, History and Physical, Operative/Procedure Report(s), Consultation Report(s), and test result(s); At MCJ - Most Recent Return Visit, History and Physical, Consultation and Test Result(s).*

IDENTIFYING INFORMATION AT THE TIME OF SERVICE:

_____ *Patient's Full Name*

_____ *Patient's Social Security Number*

_____ *Address*

_____ *Patient's Date of Birth*

_____ *City/State/Zip*

_____ *Patient's Phone Number*

I understand that disclosure of the information in this medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information relating to behavioral or mental health services or treatment, and treatment for substance abuse.

I understand that this authorization will expire in one year from the date signed below unless otherwise specified: _____

I understand that I may be charged for copies of this information in accordance with Florida law.

I understand that once the information is disclosed, the information is subject to redisclosure and may no longer be protected by the federal privacy regulations. This form may be revoked at any time providing the information has not already been disclosed. I may revoke this authorization by notifying, in writing, the Medical Record Director, 4500 San Pablo Road, Stabile Building 195A, Jacksonville FL 32224.

I understand that Mayo will not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization.

I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ *Signature of Patient or Patient's Representative**

_____ *Relationship (if not patient)*

_____ *Date*

*If a personal representative of the patient signs the authorization, please indicate his or her authority to act.

Official Use Only

Date Received: Date Provided:	# of Pages: ☐ Mail ☐ Pick-up ☐ Other	☐ Entire MR ☐ Abstract ☐ Other_____	Processed by:
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