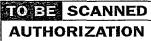


## MAYO CLINIC | Authorization to Release | TO BE SCANNED | Protected Health Information | AUTHORIZATION



		- 1010000		,			
Mayo Clinic	: Number	Name (First, Middle, Last	)		-	Birth Date (Month DD, YYYY)	
Instructions: If any section is incomplete, this form may be invalid and the request cannot be processed.							
Release Information From Release Information To							
☑ Mayo Clinic, 200 First Street SW, Rochester, MN 55905				☐ Mayo Clinic, 200 First Street SW, Rochester, MN 55905			
Attention				Attention			
☐ Other (Specify Facility & Address below, including phone/fax if known)				☑ Other (Specify Facility & Address below, including phone/fax if known)  Records Deposition Service, Inc.  P: 248-357-3330			
			P	O. Box 5054		F: 248-357-3337	
			s	outhfield, MI 480	86-5054		
Purpose of Release							
☐ Treatment/Continued Care ☐ Personal ☐ Application for Insurance ☐ Disability D			rmination	⊠ Legal Purposes ination □ Payment of Insurance Claim			
□ Other	yangan yakib didak PERSENTEN YANGAN YANGAN YANGAN PERSENTEN PERSENTEN PERSENTEN YANGAN MANAN MENJAMBAN MANAN M				A PARTY OF THE PAR		
Informatio	n to be Polosed						
Information to be Released							
Service Dates (approximate)				Information Needed By (specify Date)			
☐ History and Physical ☐ EKG's ☐ Laboratory Reports ☐ Hospital Notes							
☐ Immunization Records ☐ Pathology Reports ☐ F			☐ Radiolo	Radiology Reports			
☐ Clinic Notes ☐ Operative Reports ☐ Radiology Images ☐ Billing Statements							
☑ Other please see attached letter for records wanted							
I understand the information to be released may include records related to behavioral and/or mental health care, alcohol and drug abuse							
treatment, F	IIV/AIDS, and genetics.						
This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made							
in writing to the provider/facility releasing the information. I may be charged for copies in accordance with state law. The provider/facility will not condition treatment on whether I sign the authorization. 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 authorization will expire one year from the date of signing unless I indicate an earlier date or event here:							
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.							
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:							
	☐ Parent ☐ Leg	gal Guardian					
Sig	(nature (Required)				Date Signed	(Required) (Month DD, YYYY)	
Pri	rinted Name of Person Signing (If Not Patient)						
If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may 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 exists under state or federal law. Please indicate your relationship:  Parent  Legal Guardian  Signature (Required)  Date Signe  Printed Name of Person Signing (IF Not Patient)  Mailing Address of Patient - Street							
Cit	<u> </u>		State	ZIP code	Phone		