Authorization To Release Medical Records:

PATIENT INFORMATION:

Name (print) _____ DOB _____ SSN _____

INFORMATION TO BE RELEASED FROM:

Name of facility or provider
MAYO CLINIC HEALTH SYSTEM / FRANCISCAN HEALTH CARE

Address
PATIENT SERVICES, 700 WEST AVENUE SOUTH, LACROSSE, WI 54601

INFORMATION TO BE SENT TO:

Name of designated receipient
RECORDS DEPOSITION SERVICE, INC. **P: 312.553.8900 F: 312.553.8901**

Address: **120 WEST MADISON STREET, SUITE 300** City: **CHICAGO** State: **IL** Zip: **60602**

INFORMATION TO BE RELEASED: (check one)

_____ The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)
_____ All medical records
__X__ Specific information (please specify) : **PLEASE SEE ENCLOSED SUBPOENA OR LETTER REQUEST FOR INFORMATION TO BE DISCLOSED**

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE: (please check one)

_____ Attorney _____ Insurance _____ Doctor _____ Personal __X__ Other **FOR DISCOVERY BEFORE TRIAL**

PATIENT AUTHORIZATION :

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

* EXCLUDE the following information from the records released (please initial)

_____ Drug / Alcohol abuse/treatment & diagnosis _____ Sexually transmitted disease
_____ HIV/AIDS diagnosis/treatment/testing _____ Mental illness or psychiatric diagnosis/treatment

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or **enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the** Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____
(Patient, guardian*, or Authorized representative*)

This authorization will expire 90 days from the date signed
Possible copying fee required