MAYO CLINIC

Health Information Management Services
Campus Support Center
4500 San Pablo Road
Jacksonville, Florida 32224
(904) 953-2022
Return Fax (904) 953-2242

Authorization To Disclose Protected Health Information

PLEASE PRINT

RELEASE INFORMATION FROM	DISCLOSE INFORMATION TO
☐ Mayo Clinic (MCJ) ☐ Other (Specify Facility/Address) ☐ Pharmacy _____ _____ _____	☐ Mayo Clinic (MCJ) Health Information Management Services ☒ Other (Specify Facility/Address) **RECORDS DEPOSITION SERVICE, INC.** **PO BOX 5054** **SOUTHFIELD, MI 48086-5054** **P: 248.357.3330 F: 248.357.3337**

PURPOSE OF DISCLOSURE

☐ Continued Care (abstract* will be provided, unless otherwise specified)
☐ Personal - **I understand that** I may be charged for copies of this information in accordance with Florida Law.
☒ Other **FOR DISCOVERY BEFORE TRIAL**

INFORMATION TO BE DISCLOSED (Specify service dates _____)

☐ HOSPITAL Abstract (*includes, as applicable, Discharge Summary, Discharge Medication List, History & Physical, Operative/Procedure Report(s), ED Report(s), Consultation Report(s), and test result(s)*
☐ CLINIC Abstract (*includes, as applicable, most recent Return Visit, History & Physical, Consultation Report(s), Summary Lists, and test result(s)*
☐ Other _____

IDENTIFYING INFORMATION AT THE TIME OF SERVICE

_____ *Patient's Full Name*

_____ *Patient's Social Security Number/Medical Record 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, treatment for substance abuse, or genetic test results.

I understand that this authorization will expire in one year from the date signed below unless otherwise specified_____.

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 Health Information Management Supervisor, 4500 San Pablo Road, Campus Support Center, 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.

X _____ *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

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