MAYO CLINIC LABORATORIES

# *Authorization to Release Protected Health Information – MCL*

M M L R O I

Form content not retained in medical record. **Route to MCL for scanning.**

Mayo Clinic Laboratories, Attn: MLI, P.O. Box 4100, Rochester, MN 55901 Phone 507-284-3050 Fax 507-284-1759 RSTMCLROI@mayo.edu

| Patient Name *(Last, First, Middle)* | Birth Date *(mm-dd-yyyy)* | Patient ID/Medical Record Number |
|---|---|---|
| | | |

## Health Care Facility Order Was Received From

☐ Hospital ☐ Clinic ☐ Physician's Office ☐ Reference Lab (Specify facility/individual and address below. Include phone and fax, if known.)

| Facility Name | | | Street Address | |
|---|---|---|---|---|
| City | State | ZIP Code | Phone | Fax |
| | | | | |

## Release Information From

☐ Mayo Clinic Laboratories, Attn: MLI, P.O. Box 4100, Rochester, MN 55901

## Release Information To

☐ Self ☐ Legal Guardian ☐ Other (Specify facility/individual and address below. Include phone and fax, if known.)

| Facility Name | | | Street Address | |
|---|---|---|---|---|
| City | State | ZIP Code | Phone | Fax |
| | | | | |

## Purpose of Release

☐ Treatment or continued care ☐ Personal ☐ Legal purposes ☐ Other (specify):

## Information to Be Released

| Service Dates *(mm-dd-yyyy)* From: To: | ☐ Laboratory reports ☐ Pathology reports |
|---|---|
| If **any** section is incomplete, this form may be invalid. For FAQ, refer to the following link: https://www.mayocliniclabs.com/customer-service/patient-reports.html | |

I understand the information to be released may include records related to behavioral or mental health care, alcohol and drug abuse treatment, HIV/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 or facility releasing the information. The provider or facility will not condition treatment on whether I sign the authorization. **I may be charged for copies in accordance with state law.** 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: _____

## Signature

**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.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized substitute may 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 ☐ Legal Guardian

| Signature (required) ▶ | Date (required) *(mm-dd-yyyy)* |
|---|---|
| Printed Name of Person Signing (if not patient) *(Last, First, Middle)* | |

| Patient Street Address | City | State | ZIP Code |
|---|---|---|---|
| | | | |

| Phone | Fax | Email |
|---|---|---|
| | | |