Clear Form

MAYO CLINIC HEALTH SYSTEM

Authorization to Release Health and/ or Behavioral Health Care Information

Patient Label

Staff Use ONLY:
☐ ROI Send Records ☐ Forms Completion to Process ☐ Scan to Chart ☐ Information Released_____ Date_____ Initials

1. Patient Information • Please print legibly. Each section needs to be completed to be valid.

Patient Name *(First, Middle, Last)*	Medical Record Number (if known)	
Previous/Maiden Name	Birth Date *(Month DD, YYYY)*	
Street Address	Phone	
City	State	ZIP Code

2. Release Information FROM • Check box(es) or write in facility/treatment site who has your information to be released.

☐ **Mayo Clinic Health System locations in Northwest Wisconsin:** - may specify site(s):_____
☐ **Mayo Clinic Health System locations in Southwest Wisconsin:** - may specify site(s):_____
OR if other Provider enter that complete information below**:**

Person/Organization		
Street Address		
City	State	ZIP Code

3. Release Information TO • Print name, phone, and complete address of party to receive the information.

Person/Organization	Attn/Dept	
Street Address	Phone	
City	State	ZIP Code

☐ **Check box if allowing Mutual Exchange of Information between above parties**

4. Purpose for Disclosure • Check appropriate box or write in if other purpose.

☐ Continued Care/Treatment ☐ Disability ☐ Insurance ☐ Legal ☐ Personal ☐ Work Comp
☐ Other_____

5. Delivery of Information

There may be a possible fee/charge for copies of records.

Date information is needed by:
Information will be mailed unless specified:

D10133

MCHS30022rev0616

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Name: _____

DOB *(Month DD/YYY)*: _____

(or apply label)

6. Information to be Released (Follow instructions per subsections below)

A. Manner Of Disclosure For Health and Billing Information: (Check applicable boxes)

☐ Verbal (also complete subsections B & C below) ☐ Viewing of Record (onsite by party listed in #3)

☐ Written (may include completed forms, also complete subsections B, C & D below)

B. Date(s) or Year(s) to be released: _____

OR Only information relating to specific Illness/injury: _____

Date/timeframe of the specific illness/injury: _____

C. Record Types - If applicable, check boxes to allow information to be released per WI Statutes 252.15 & 51.30.

☐ HIV Lab Test Results ☐ Behavioral Health Records ☐ Alcohol and/or Drug Abuse Treatment

D. Written Records/Reports To Be Released: Check box(s) for document types to be released.

☐ Hospital Notes	☐ Office Visits/Notes	☐ Lab/Pathology	☐ Other Diagnostic	☐ Residential Stays
☐ ED/Urgent Care	☐ Medication List	☐ Radiology Reports	☐ Neuropsych	☐ Home Health/Hospice
☐ Oper/Procedure	☐ Immunizations	☐ Radiology Images	☐ Therapy/Rehab	☐ Billing Information

☐ Other (Please Specify): _____

OR ☐ **Check here if only allowing completion/release of forms(s)** - no copies of records to be released.

7. Signature and Date

- This authorization may be revoked at any time by providing a written notice of revocation to the HIMS ROI Department at the facility releasing the information, except to the extent that the Providers checked above have already taken action in reliance on it.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Rules.
- I understand that Mayo Clinic Health System will not condition treatment on whether I sign this authorization.
- A photocopy of this authorization is as valid as the original. • The patient may receive a copy of the signed authorization upon request.
- The patient has a right to inspect and receive a copy of the material to be disclosed.
- **This authorization will expire in one year unless otherwise specified:** _____ .

☐ **By checking (√) this box I also authorize the release of records for future visits/stays until the expiration of this authorization.**

Note: An adult patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. Legal documentation of the right of access by the signing individual may be required. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Signature *(required)*	**Date** *(required)* *(Month DD, YYY)*
Printed Name of Person Signing *(if not patient)*	☐ Check if patient is deceased

Relationship if ***not*** Patient: ☐ Parent ☐ Legal Guardian ☐ Activated Health Care Power of Attorney Agent

MCHS locations in Northwest Wisconsin	MCHS locations in Southwest Wisconsin
Includes MCHS sites: Eau Claire; Barron; Rice Lake; Cameron; Chetek; Bloomer; Chippewa Falls; Menomonie; Glenwood City; Elmwood; Osseo; Mondovi	Includes MCHS Wisconsin sites: La Crosse; Arcadia; Holmen; Tomah; Onalaska; Prairie du Chien; Sparta; Caledonia, MN; La Crescent, MN; Waukon, IA
HIMS - Release of Information: 1400 Bellinger Street Eau Claire, WI 54703-5211 Phone: 715-838-6395 Fax: 715-838-3058	**HIMS - Release of Information:** 800 West Ave. South La Crosse, WI 54601 Phone: 608-392-6275 Fax: 608-392-9799