



**Authorization to Release Information**  
**BY Mayo Clinic**

I authorize Mayo Clinic Rochester to disclose any information (including, but not limited to, information relating to psychiatric/psychologic, sickle cell anemia, and alcohol and drug diagnosis and treatment or information from its affiliated entities, if any such information exists) that it possesses regarding \_\_\_\_\_  
(Name of Patient)

whose Mayo Clinic Registration Number is \_\_\_\_\_ and who was born on \_\_\_\_\_

to the current treating health care provider or **MINUTE MAN PROCESS AND LEGAL SERVICE, INC.**  
(Name and address of person or organization to whom disclosure is authorized)

3318 North Main, Royal Oak, MI 48072

This disclosure is authorized for the purpose of \_\_\_\_\_

This authorization will terminate in one year or upon specified date or event: \_\_\_\_\_

As stated in Mayo Clinic's Notice of Privacy, this authorization may be revoked at any time except to the extent that Mayo has taken action in reliance upon this authorization. Revocation must be made in writing to the following appropriate entity: Mayo Clinic, Office of Patient Affairs, 200 First Street SW, Rochester, MN 55905

Furthermore, I understand that Mayo Clinic will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization.

I understand that a copy of this authorization will be provided to me when Mayo Clinic receives the authorization.

I understand, that if this information is disclosed to a third party, the information may be redisclosed by the person or entity that receives the information and may no longer be protected by federal privacy regulations.

I also understand that I may be charged for copies of this information in accordance with state law.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Patient (if not patient)