



Mayo Clinic Authorizations and Service Terms

Form content retained in medical record.
Route to HIMS Scanning.

(complete fields or place patient label here)

Patient Name (First, Middle, Last)	
Birth Date (mm-dd-yyyy)	Room Number (if applicable)
Mayo Clinic Number	

**TO BE
SCANNED**

Authorizations

Authorization for Treatment: I consent to the rendering of medical care which may include routine diagnostic procedures and such medical treatment as my attending physician(s) or other Mayo Clinic* (Mayo) medical staff consider to be necessary. I may be offered medical services via telemedicine systems that involve the delivery of health care by electronic communication with a provider who is at a different physical location, and I consent to such services. I understand that my medical care and treatment may be provided by physicians, including fellows and residents, medical and allied health students, physician assistants, nurses and other health care providers. I have read and understand this Authorization for Treatment and understand that no guarantee or assurance has been made as to the results that may be obtained.

Authorization to Release Medical Information:** I authorize Mayo to release all medical information as necessary to:

- All Payers*** for processing health care claims;
- The person(s) I designate as my Billing Addressee/Guarantor for handling the billing, payment, and health care coverage for my account;
- Accrediting and quality organizations, regulatory agencies, public health reporting agencies, or other persons or entities for health care operations;
- My other health care providers for treatment or payment purposes; and
- Mayo entities for the purpose of providing information regarding the services and goods of Mayo and/or its affiliates that may be of interest to me. I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or entity that receives the information in accordance with applicable law. Mayo may not condition treatment, payment, enrollment, or eligibility for benefits on my agreeing to this provision.
- I authorize Mayo and my insurer(s) to share my past, current and future health, treatment and account records about services I've received from Mayo and other care providers as needed to manage or coordinate my care and to improve the quality of that care.
- A health record locator service/health information exchange (HIE) allows my health care providers to electronically access my health information held by other participating providers to provide me with better care. I authorize Mayo to access any of my health information that is available in an HIE, and Mayo will also make my Mayo health information available through HIEs in which it participates unless I opt out. If I opt out, by checking the box below, Mayo will exclude all of my Mayo health information from the HIEs in which Mayo participates. **HIE Opt Out**

Authorization to Assign Benefits and Release Information to Mayo: I authorize my Payer(s) to pay directly to Mayo any benefits due under the terms of my health care plan(s), for services provided by Mayo. I understand Mayo reserves the right to refuse or accept assignment of medical benefits. If I am a Medicare beneficiary, I request payment of authorized Medicare benefits to me or Mayo on my behalf for any services furnished. If my health care plan(s) will not allow direct payment to Mayo or if Mayo chooses not to accept assignment of medical benefits, I agree to pay Mayo all health care payments I receive for services. I authorize Mayo to contact my Payer(s) to obtain all pertinent financial information concerning coverage and payments made under my health care plan(s) and for my Payer(s) to release such information to Mayo.

Service Terms

Statement of Financial Responsibility: I acknowledge I am responsible for all charges for services provided, including any amount not paid by my health care plan(s), other than billing terms and restrictions under a government program. I authorize Mayo to apply any credit balance on my account to any amounts that I may owe to one or more Mayo entities. I agree that Mayo may obtain financial information, including consumer credit reports to determine eligibility for financial assistance and/or payment options. Information on financial assistance is available by calling 800-660-4582, or at mayoclinic.org or mayoclinichealthsystem.org.

Dispute Resolution: I agree that any dispute (including personal injury claims) related to health care services rendered by Mayo is subject to the exclusive jurisdiction of the appropriate court in the state where the provider of the disputed services is physically located when the services are rendered and the law of that state. Any state court action must be venued in the county where the provider of the disputed services is physically located when the services are rendered. These agreements also apply to my legal representatives and next of kin.

Use of Phone: I agree Mayo, its affiliates and agents may use an automated telephone dialing system, pre-recorded messages, and texting, to contact the wireless number(s) and/or residential lines I provide to Mayo for appointment and payment purposes.

Notice of Privacy Practices: I acknowledge I have been presented with the Mayo Notice of Privacy Practices, which can be viewed at: <http://www.mayoclinic.org/about-mayo-clinic/notice-of-privacy-practices>. I can request a paper copy during my visit or by calling 507-266-6286.

ATTENTION: This is a legal document. Changes will not be accepted on this form. Requests for any alterations must be made by calling at 507-284-3350. By signing, I agree that I understand and accept the terms on this form. *I understand I have the right to revoke the authorizations on this form at any time by notifying Mayo in writing, except to the extent that Mayo has already taken action in reliance upon them. These authorizations will remain valid until I revoke them in writing.*

- 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)
 - Other Legal Representative
- 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	Signature Date	Signature Time
Printed Name of Person Signing (If Not Patient)		

* For purposes of this form, Mayo refers to Mayo Clinic in Arizona, Florida, Rochester, Mayo Clinic Health System and all affiliated clinics, hospitals, and entities; including employees and agents.

** Medical information includes, but is not limited to, information related to psychologic, psychiatric, sickle cell anemia, HIV/AIDS, communicable diseases, genetic testing, and alcohol and drug abuse diagnosis and treatment if such information exists.

*** For purposes of this form, Payer(s) includes, but is not limited to, insurance carriers, health-plan administrators, or any other payers including the Centers for Medicare & Medicaid (CMS) and their agents or review agencies.



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