

Mental Health Center Authorization
Release of Protected Health Information and Verbal Disclosure

Patient Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Phone _____ Previous/Maiden Name _____

1. I authorize the disclosure / release of my Mental Health / Substance Abuse information from Myrtue Medical Center to:

Name _____ Address City / State / Zip _____
Phone _____ Email _____

2. The purpose of releasing or obtaining the information is:

- Continuity of Care Personal Legal Insurance/Billing Other (list) _____

3. Information to be disclosed / released from:

a. Mental Health Center

- Communication: Verbal (in person or telephone including messages) and / or encrypted email completed by Mental Health Center.

OR

b. Health Information Management (HIM) Department

- **Provide date(s) of service from (date) _____ to (date) _____**
 - Attendance Only Mental Health Records Substance Abuse Records
 - Other (list) _____
- **Check mark disclosure format and delivery method:**
 - MyChart Portal Encrypted email: _____
 - Mail I will pick up at Myrtue Medical Center

4. By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- This authorization is effective until the calendar date of *___/___/_____ however no longer than 1 year from the date on which it was signed.
- I understand I have the right to revoke my permission at any time except where Myrtue Medical Center has already made disclosures with this request. Revocation must be made in writing to the Health Information Management Department.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon if I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- Information disclosed may contain information about alcohol / drug abuse, mental / behavioral health, sexually transmitted diseases, AIDS, HIV, or self-paid services.
- I authorize the release of this form to the individual named on this form.

Prohibition on Re-Disclosure of Substance Use Disorder Records: Substance Use Disorder records are protected by Federal law which prohibits unauthorized disclosure of these records. Upon my request, I have the right to receive a list of entities that have received my substance use disorder information.

Patient or Authorized Representative Signature

Printed Name

Date

Relationship to Patient (if applicable)

Staff Use Only: Date Received _____ MRN _____ Released By _____ Released Date _____ Verified: Driver's License ID Band Other _____

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ADDENDUM

Patient Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Phone _____ Previous/Maiden Name _____

1. I authorize the disclosure / release of my **Mental Health / Substance Abuse** information from Myrtue Medical Center to the **additional** individual identified below.

Name _____ Address City / State / Zip _____

Phone _____ Email _____

2. **The purpose of releasing or obtaining the information is:**

- Continuity of Care Personal Legal Insurance/Billing Other (list) _____

3. **Information to be disclosed / released from:**

a. **Mental Health Center**

- Communication: Verbal (in person or telephone including messages) and / or encrypted email completed by Mental Health Center.

4. **By signing this authorization form, I understand that:**

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- This authorization is effective until the calendar date of *___/___/____ however no longer than 1 year from the date on which it was signed. I understand this **ADDENDUM** will not alter the effective date of the most current authorization.
- I understand I have the right to revoke my permission at any time except where Myrtue Medical Center has already made disclosures with this request. Revocation must be made in writing to the Health Information Management Department.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon if I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- Information disclosed may contain information about alcohol / drug abuse, mental / behavioral health, sexually transmitted diseases, AIDS, HIV, or self-paid services.
- I authorize the release of this form to the individual named on this form.

Prohibition on Re-Disclosure of Substance Use Disorder Records: Substance Use Disorder records are protected by Federal law which prohibits unauthorized disclosure of these records. Upon my request, I have the right to receive a list of entities that have received my substance use disorder information.

Patient or Authorized Representative Signature

Printed Name

Date

Relationship to Patient (if applicable)