MYRTUE Medical Center

Health Information Management
1213 Garfield Avenue
Harlan, Iowa 51537
Phone: 712-340-1312 / Fax: 712-755-2640
medicalrecords@myrtuemedical.org

HIPAA Privacy Form

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 Use** 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)_____

☐ For Substance Use Disorder: Civil, criminal, administrative and legislative proceedings against the patient require a court order, subpoena or similar legal mandate unless the patient or authorized representative signs this form.

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 Use 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 substance use disorder, mental 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 ____

Permanent Part of the Medical Record; Dev. 07/25, Rev. 02/26, 05/26, 10/26

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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 Use** 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)_____

☐ For Substance Use Disorder: Civil, criminal, administrative and legislative proceedings against the patient require a court order, subpoena or similar legal mandate unless the patient or authorized representative signs this form.

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 substance use disorder, mental 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.

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Patient or Authorized Representative Signature | Printed Name

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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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