MYRTUE Medical Center

Health Information Management
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Harlan, Iowa 51537
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medicalrecords@myrtuemedical.org

Consent for Disclosure
Permission to Leave Phone Messages and / or Verbally Discuss Protected Health Information

Patient Name_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Phone_____ Previous/Maiden Name_____

I give permission for Myrtue Medical Center to verbally share my medical information with the following individual(s) identified below who are involved with my care or payment for my care. This permission allows verbal, in person or telephone communication including telephone messages. In addition, I authorize Myrtue Medical Center to leave messages on my telephone.

If the below is not completed, I only authorize Myrtue Medical Center to leave messages on my telephone.

Name		**Relationship**	
Phone		If minor, Mother / Legal Guardian	

Name		**Relationship**	
Phone		If minor, Father / Legal Guardian	

Name		**Relationship**	
Phone			

Name		**Relationship**	
Phone			

Please check each box of information which is further protected by law:

☐ Substance Use/Abuse (drug and alcohol) ☐ Mental Health

I understand in certain situations Myrtue Medical Center may speak to other individuals who are involved in my care or payment for my care, if permitted by law, who may not be identified on this form. I understand, any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. **This Consent for Disclosure will remain in effect for one (1) year from the date 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.

_____ _____ _____

Patient or Authorized Representative Signature | Relationship | Date

Permanent Part of the Medical Record; Dev. 05/17, Rev. 06/21, 03/23, 12/24, 07/25, 05/26