



Authorization to Release Protected Health Information

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

I authorize the disclosure / release of my information (request must have complete addresses):

From:

Myrtue Medical Center, 1213 Garfield Ave, Harlan IA 51537
 Mental Health Center, 1220 Chatburn Ave, Harlan IA 51537
 Community Health 2712 12th St. Harlan IA 51537
 Other: Name _____
 Address _____
 City/State/Zip _____
 Phone/Fax _____ / _____

To:

Myrtue Medical Center, 1213 Garfield Ave, Harlan IA 51537
 Mental Health Center, 1220 Chatburn Ave, Harlan IA 51537
 Community Health 2712 12th St. Harlan IA 51537
 Other: Name _____
 Address _____
 City/State/Zip _____
 Phone/Fax _____ / _____

Information to be disclosed/released. Date(s) of service from _____ (date) to _____ (date)

- Entire medical record (does not include substance abuse disorder records)
- Radiology Reports
- Substance Use Disorder
- All records
- Mental Health records
- Images (CD Only)
- Only the following records _____
- Laboratory / Pathology reports
- Other (list) _____

The purpose of releasing or obtaining the above information is:

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

Check mark disclosure format and delivery method:

- MyChart Portal
- Encrypted email: _____
- Mail
- I will pick up at Myrtue Medical Center Community Health

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.
- I have the right to revoke this authorization at any time, except where Myrtue Medical Center has already acted in reliance on my authorization. Revocation must be made in writing to the Health Information Management Department.
- This authorization is effective until the calendar date of * ___/___/_____ however no longer than 1 year from the date on which it was signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on 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.

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.

 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 _____