MYRTUE Medical Center

Authorization for Release of Protected Health Information
Phone: 712-755-4368
Fax: 712-755-2640

Patient Name: _____ **Birth Date**: _____

I hereby authorize the following facility to release my health information as noted below:

Release Information FROM:

- ☐ Myrtue Medical Center, 1213 Garfield Ave, Harlan, IA 51537
- ☐ Behavioral Health Clinic, 1303 Garfield Ave, Harlan, IA 51537
- ☐ Community Health, 2712 12th St, Harlan, IA 51537
- ☐ Other (Specify Facility and Address)

_____
_____
_____

Release Information TO:

- ☐ Myrtue Medical Center, 1213 Garfield Ave, Harlan, IA 51537
- ☐ Behavioral Health Clinic, 1303 Garfield Ave, Harlan, IA 51537
- ☐ Community Health, 2712 12th St, Harlan, IA 51537
- ☐ Other (Specify Facility and Address)

_____
_____
_____

Purpose of Release:

☐ Treatment/Continued Care ☐ Personal ☐ Legal ☐ Insurance use ☐ Disability
☐ Worker's Comp ☐ Change of Physician ☐ Other: _____

Information to Release:

Date(s) of Service (be specific): _____ ☐ All records (fee may apply)

☐ History and Physical ☐ ER Report ☐ Lab Report ☐ Radiology Report
☐ Discharge Summary ☐ Consultation ☐ Operative Report ☐ Pathology Report
☐ Orders/Progress Notes ☐ EKG ☐ Future lab reports ☐ Other: _____

I hereby specifically authorize the release of data and information relating to: (check all that apply, sign and date)

☐ HIV (including AIDS information) ☐ Mental Health ☐ Substance Abuse (including alcohol/drug abuse)

Signature: _____ Date: _____

This authorization is effective until _____ or for 180 days from the date on which it is signed, whichever is longer. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written or oral notice to the Medical Records Department of Myrtue Medical Center at the address listed above. Myrtue Medical Center cannot condition treatment or payment based on the signature on this authorization for disclosure. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signature: _____ **Phone #** _____ **Date**: _____
(Patient or Patient's Authorized Representative)

Relationship to Patient: _____ ☐ I would like a copy of this authorization.

Internal Use Only: MR #: _____ Date Completed: _____ Initials: _____ Rev. 8/18