MYRTUE Medical Center

Authorization for Release of Protected Health Information

Hospital Phone: 712.755.5161 Fax: 712.755.2640
Clinic Phone: 712.755.5130 Fax: 712.755.4445
Behavioral Health Phone: 712.755.5056 Fax: 712.755.7143

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
- ☐ Harlan Clinic, 1220 Chatburn Ave, Harlan, IA 51537
- ☐ Avoca Clinic, 510 N. Elm, Avoca, IA 51521
- ☐ Elk Horn Clinic, 4022 Main St, Elk Horn, IA 51531
- ☐ Shelby Clinic, 301 East St, Shelby, IA 51570
- ☐ Earling Clinic, 100 Industrial Rd, Earling, IA 51530
- ☐ 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
- ☐ Harlan Clinic, 1220 Chatburn Ave, Harlan, IA 51537
- ☐ Avoca Clinic, 510 N. Elm, Avoca, IA 51521
- ☐ Elk Horn Clinic, 4022 Main St, Elk Horn, IA 51531
- ☐ Shelby Clinic, 301 East St, Shelby, IA 51570
- ☐ Earling Clinic, 100 Industrial Rd, Earling, IA 51530
- ☐ Behavioral Health Clinic, 1303 Garfield Ave, Harlan, IA 51537
- ☐ Community Health, 2712 12th St, Harlan, IA 51537
- ☐ Other (Specify Facility and Address)

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Purpose of Release:

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

Information to Release:

Dates of Service (to and from): _____

☐ History and Physical ☐ ER Report ☐ Lab Report ☐ Radiology Report
☐ Discharge Summary ☐ Consultation ☐ Operative Report ☐ Pathology Report
☐ Orders/Progress Notes ☐ EKG ☐ 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 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. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.

Signature: _____ **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: _____