MYRTUE Medical Center

Consent for Disclosure
Myrtue Medical Center
Permission to Leave Messages and / or Verbally Discuss Protected Health Information with Family, Friends and Others

Patient Name (First, Middle, Last)	Date of Birth	Phone Number

I give permission for Myrtue Medical Center to leave medical information messages about myself on my cell or home phone. ☐ **Yes** ☐ **No**

I give permission for Myrtue Medical Center to verbally share the information checked below with the family, friends or others that I have identified below as being involved in my health care or payment of my health care. ***(check all boxes that apply):***

- ☐ Scheduling / appointment / attendance / participation information
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Lab / test results
- ☐ Billing and payment information

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

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

_____	_____	_____
Patient or Authorized Representative Signature	Relationship	Date

Identify family member, friend or other person.

Name	Address	Relationship	Phone Number

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 I have the right to revoke my permission at any time except where Myrtue Medical Center has already made disclosures in reliance upon this request. 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 until _____ or one (1) year from the date on which it is signed, whichever is longer or until revoked by myself or my authorized representative.

_____	_____	_____
Patient or Authorized Representative Signature	Relationship	Date

_____	_____
Witness Signature	Date

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PATIENT OR AUTHORIZED REPRESENTATIVE INFORMATION

How can I give others permission to get verbal information about me?
Complete the Consent for Disclosure, Permission to Verbally Discuss Protected Health Information with Family, Friends and Others form on the reverse side of this page to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss.

Where do I send the completed form or any changes?
Please send or fax the completed form or ask hospital / clinic staff to send it for you to the below contact information.

Does this mean that you will not speak to anyone I haven't specifically named on the form?
No. If permitted by law, Myrtue Medical Center may speak to other individuals involved in your care or payment for your care.

What are some examples of when this might be useful?
- If an individual wants to share information with spouse or significant other
- If an elderly parent wants an adult child to help understand medical treatment instructions
- If an adult child is helping with billing questions
- If a friend is helping a patient with health issues
- If a college student wants information shared with a parent
- If an adult child calls to find out his/her parent's appointment time

What if I change my mind?
You can change or revoke (stop) this process at any time by writing to us at the address shown above. Forms are available at your provider's office, or you can obtain a form from the below contact information.

Can the person I designate also get copies of my medical records?
No, they can only receive verbal information. To get copies of medical records, a separate Authorization form must be completed. You may obtain the Authorization form at your provider's office or at the below contact information.

Health Information Management
1213 Garfield Avenue
Harlan, Iowa 51537
Phone: 712.755.4368
medicalrecords@myrtuemedical.org
myrtuemedical.org