Patient 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):

To:

- ☐ Myrtue Medical Center, 1213 Garfield Ave, Harlan IA 51537
- ☐ Behavioral Health 1110 Morningview Dr, Harlan IA 51537
- ☐ Community Health 2712 12th St. Harlan IA 51537

Other: Name_____

Address_____

City/State/Zip_____

Phone/Fax_____/_____

From:

- ☐ Myrtue Medical Center, 1213 Garfield Ave, Harlan IA 51537
- ☐ Behavioral Health 1110 Morningview Dr, 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).

- ☐ Abstract (discharge summary, history and physical, operative reports, consultations, test results
- ☐ Entire medical record (does not include substance abuse disorder records)
- ☐ Discharge summary
- ☐ Laboratory/Pathology reports
- ☐ Employee Health records
- ☐ Radiology
  - ☐ Reports
  - ☐ Images (CD Only)
- ☐ Sexually transmitted disease records including HIV/AIDS
- ☐ Physical/occupational therapy
- ☐ Immunization records
- ☐ Emergency department records
- ☐ Substance Use Disorder
  - ☐ All records
  - ☐ Only the following records_____
- ☐ Mental / Behavioral Health records
- ☐ Billing records
- ☐ Medication records
- ☐ Other (list)

The purpose of releasing or obtaining the above information is:

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

Disclosure format and delivery method:

☐ MyChart Portal **OR** ☐ Encrypted email:_____

☐ Mail **OR** ☐ 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 (contact information listed on page 2).
- Unless otherwise revoked, this authorization remains valid until its expiration date or event, but not greater than one (1) year. Event Date:_____
- 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.

_____ _____

Patient or Authorized Representative Signature Printed Name

_____ _____

Date Relationship to Patient (if applicable)

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Please allow a minimum of 72 hours or three business days to process after the written request is received.

Requesters will be contacted for additional information if forms are incomplete.

Please submit this completed form to:

Health Information Management

1213 Garfield Avenue

Harlan, Iowa 51537

Phone: 712-755-4368 / Fax: 712-755-2640

medicalrecords@myrtuemedical.org

Hours of Operation: Monday – Friday 8am - 4:30pm

Myrtue Medical Center Pickup Locations

Myrtue Medical Center
1213 Garfield Avenue
Harlan, IA 51537

Community Health Department
2712 12th Street
Harlan, IA 51537

* Communications sent by email over the internet are not secure. There is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.

Myrtue Medical Center Staff Use Only

Date Received_____ Location_____ MRN_____

Page Count_____ FIN#_____ Released By_____

Released Date _____ Verified By □ Driver's License □ ID Band □ Other _____