MYRTUE Medical Center

Health Information Management
1213 Garfield Avenue
Harlan, Iowa 51537
Phone: 712-755-4368 / Fax: 712-755-2640
medicalrecords@myrtuemedical.org

HIPAA Privacy Form

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
□ Behavioral Health 1110 Morningview Dr, 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
□ 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)

□ Entire medical record (does not include substance abuse disorder records)
□ Mental / Behavioral Health records
□ Radiology
□ Reports
□ Images (CD Only)
□ Laboratory / Pathology reports
□ Substance Use Disorder
□ All records
□ Only the following records_____
□ 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 ____