Mary Greeley MEDICAL CENTER

MGMC USE ONLY	Date Released:	Released by:
	MRN:	Comments:

1. Patient Information

Name (Last , First, Middle Initial)	Date of Birth	Phone	
Street Address	City	State	Zip Code

2. Exchange of Information between:

Name		
MGMC (Mary Greeley Medical Center)		
Address		Phone/Fax
1111 Duff Ave		ph515-239-2046 fax515-239-2049
City	State	Zip Code
Ames	Iowa	50010

Circle one:

Send to:

or

Obtain from:

3. And (only 1 person, organization, phone# per authorization)

Name (insurance co., lawyer, school, physician, patient, other)		
Address		Phone/Fax
City	State	Zip Code

4. Information to be disclosed: Please indicate verbal and/or written.

___ Written / electronic medical record, please specify what is requested:

Dates or Conditions_____ Other_____

___ Exchange of verbal communication between entities noted in Section 2 and Section 3.

5. Purpose of need for disclosure: ☐ Care Coordination ☐ Legal ☐ Other as specified_____

This authorization is voluntary. Refusal to sign will not affect the patient's ability to obtain treatment, payment or if applicable, enrollment in a health plan or eligibility of benefits. Please note if the patient record is provided in an unencrypted format, Mary Greeley Medical Center cannot ensure the privacy of the information. Other formats may be considered depending on system constraints. Please note minimum necessary guidelines are followed for all requests.

6. I specifically authorize the release of information related to (check all that apply):

☐ Mental Health ☐ HIV-related (including AIDS testing) ☐ Substance abuse treatment ☐ Genetic testing

Signature_____ Date_____ Time_____

Mental health and substance abuse records may be released without specific consent from the patient to Iowa law 'for purposes of care coordination' if not otherwise restricted by federal law or regulation, or as otherwise defined in Notice of Privacy Practice available at www.mgmc.org.

7. Signature of Patient/Representative_____ Date_____ Time_____

Relationship to patient if signed by representative_____

8. This authorization expires SIX MONTHS from the date of the signature unless otherwise noted here:_____

This authorization may be revoked by notifying Mary Greeley Medical Center in writing:
Privacy Officer c/o Mary Greeley Medical Center, 1111 Duff Ave, Ames, IA 50010

9. Notice: Protected health information may already have been disclosed before the revocation is received. If so, the revocation will be effective only as of the date is it received by the medical center. If the recipient of the information disclosed pursuant to this authorization is not a health care provider, health plan or health care clearinghouse, the information may be subject to disclosure by the recipient and may no longer be protected by federal privacy laws and regulations.

10. A copy of this completed authorization is available up on request.