GMHC
Guttenberg Municipal Hospital & Clinics
An Affiliate of MERCYONE

Release of Information for Family Member/Friend

I, _____, direct the health care and medical service providers of Guttenberg Municipal Hospital & Clinics (AKA Cornerstone Family Practice of Guttenberg, Edgewood & Garnavillo), 200 Main St, Guttenberg IA 52052, to disclose and release my protected health information as described below to:

Name: *Relationship:*

_____ _____

Contact information: _____

Name: *Relationship*:

_____ _____

Contact information: _____

Health Information to be disclosed at the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):

    _____
    _____

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____

unless I revoke it. (NOTE: *You may revoke this authorization at any time by notifying your health care providers, preferably in writing*.)

_____ _____
Printed Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524