Katahdin Valley Health Center
Authorization to Release and Disclose Protected Health Information (PHI)

Note: All applicable fields must be completed for this form to be considered valid.

PATIENT INFORMATION:	**I am a NEW PATIENT to KVHC Primary Care ☐ YES ☐ NO**				
Name:				**Date of Birth:**	
Address:				**Phone:**	
City:		**State:**		**Zip Code:**	

I HEREBY AUTHORIZE KATAHDIN VALLEY HEALTH CENTER TO:					
Please check ONLY one:	**☐ Release my records to:**	**☐ Request my records from:**	**☐ Communicate verbally with:**		
Name/Facility:					
Address:					
City:		**State:**		**Zip Code:**	
Phone:		**Fax:**			

INFORMATION TO BE RELEASED/REQUESTED: *(Please check all that apply)*

Dates of service to be released/requested: **☐ Last 2 years** **OR** _____ / _____ / _____ **to** _____ / _____ / _____

☐ Entire Medical Record ☐ Entire Dental Record

To ensure a complete patient record, please include the most recent (if applicable):

- Current Medication List
- Current Problem List
- Summary of Medical History
- Immunization Record
- Labs
- Pap & Pathology Report
- Colonoscopy
- Mammogram
- Eye Exam
- Current dental x-rays, including full panorals

☐ Behavioral Health Records ☐ Lab Reports

☐ Immunization Record ☐ Mammograms

☐ Imaging Reports (MRI/CT/X-Ray):_____

☐ Other *(please specify)*:_____

(Such as Physical Therapy, Chiropractic, Pain Management, Podiatry, Optometry, Dental, or Mental Health)

☐ Exclusions: _____

SENSITIVE INFORMATION TO BE RELEASED: *(all four questions below must be answered)*

I understand that the information to be released may contain sensitive information and that by checking the appropriate boxes below, I hereby authorize the release of the following types of information:

☐ I **DO** ☐ I **DO NOT**	permit the release of any information relating to **Alcohol, Substance, and/or Drug Use**.
☐ I **DO** ☐ I **DO NOT**	permit the release of any information relating to diagnosis or treatment of **Mental/Behavioral Health**.
☐ I **DO** ☐ I **DO NOT**	wish to review my information related to mental health / behavioral health before it is released. I understand that my review must be supervised.
☐ I **DO** ☐ I **DO NOT**	authorize the disclosure of information that refers to the treatment or diagnosis of **HIV-related diseases**. I understand that individuals about who such disclosures have been made have encountered discrimination from other areas of employment, housing, education, life insurance, and social and family relationships.

PURPOSE OF REQUEST: *(please select at least one)*

☐ Ongoing Treatment ☐ Personal Use ☐ Verbal Communication

☐ Transferring Care ☐ Legal Purposes ☐ Insurance Matters (Disability / Worker's Compensation)

☐ Other (please specify):_____

I ACKNOWLEDGE AND UNDERSTAND THE FOLLOWING:

- I may revoke this authorization at any time with the exception of the information already disclosed. To revoke my authorization, I must submit a written request to Katahdin Valley Health Center.
- I may refuse to disclose all or some of the information in my medical records. A refusal or revocation to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or claim for health benefits, or other adverse consequences.
- If this information is disclosed to a third party, the information may no longer be protected by state or federal privacy regulations and may be re-disclosed by the person or organization that received the information.
- I may be provided a copy of this authorization, upon request.
- Any information released may be transmitted by fax, released on a media storage device, or submitted electronically according to Katahdin Valley Health Center's policies.
- By signing this authorization, I consent to the release of any and all medical or dental information unless specified under "exclusions" above.
- I authorize future disclosures regarding these records to the same individual or entities until this form expires; **one year** from the date below, unless I write an earlier date here:_____

_____	_____	_____	_____
Patient's Signature	Printed Name	Date	Time
_____	_____	_____	_____
Authorized Representative's Signature	Printed Name	Date	Time

_____
Relationship to the Patient

WHERE TO SUBMIT RECORDS:

By mail: Katahdin Valley Health Center 529 South Patten Road Patten, ME 04765	Medical Records: New Patient Medical Records **Fax**: 207-528-8071 Medical Records **Fax**: 855-849-8457 Dental Records: Dental Records **Fax**: 855-933-2292 Dental Records **email**: dental@kvhc.org