



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 <input type="checkbox"/> YES <input type="checkbox"/> NO			
Name:		Date of Birth:			
Address:		Phone:			
City:	State:	Zip Code:			

I HEREBY AUTHORIZE KATAHDIN VALLEY HEALTH CENTER TO:					
Please check ONLY one: <input type="checkbox"/> Release my records to: <input type="checkbox"/> Request my records from: <input type="checkbox"/> Communicate verbally with:					
Name/Facility:					
Address:					
City:	State:	Zip Code:			
Phone:	Fax:				

INFORMATION TO BE RELEASED/REQUESTED: <i>(Please check all that apply)</i>					
Dates of service to be released/requested: <input type="checkbox"/> Last 2 years OR ____ / ____ / ____ to ____ / ____ / ____					
<input type="checkbox"/> Entire Medical Record		<input type="checkbox"/> Entire Dental Record		<input type="checkbox"/> Behavioral Health Records	
<input type="checkbox"/> Current Medication List		<input type="checkbox"/> Pap & Pathology Report		<input type="checkbox"/> Lab Reports	
<input type="checkbox"/> Current Problem List		<input type="checkbox"/> Colonoscopy		<input type="checkbox"/> Immunization Record	
<input type="checkbox"/> Summary of Medical History		<input type="checkbox"/> Mammogram		<input type="checkbox"/> Mammograms	
<input type="checkbox"/> Immunization Record		<input type="checkbox"/> Eye Exam		<input type="checkbox"/> Imaging Reports (MRI/CT/X-Ray): _____	
<input type="checkbox"/> Labs		<input type="checkbox"/> Current dental x-rays, including full panorals		<input type="checkbox"/> Other <i>(please specify)</i> : _____ <i>(Such as Physical Therapy, Chiropractic, Pain Management, Podiatry, Optometry, Dental, or Mental Health)</i>	
<input type="checkbox"/> Exclusions: _____					

SENSITIVE INFORMATION TO BE RELEASED: <i>(all four questions below must be answered)</i>	
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:	
<input type="checkbox"/> I DO	<input type="checkbox"/> I DO NOT permit the release of any information relating to Alcohol, Substance, and/or Drug Use.
<input type="checkbox"/> I DO	<input type="checkbox"/> I DO NOT permit the release of any information relating to diagnosis or treatment of Mental/Behavioral Health.
<input type="checkbox"/> I DO	<input type="checkbox"/> 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.
<input type="checkbox"/> I DO	<input type="checkbox"/> 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.



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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): _____

ATTESTATION REGARDING USE OR DISCLOSURE OF PHI POTENTIALLY RELATED TO REPRODUCTIVE HEALTH CARE

- I attest that the use or disclosure of PHI that I am requesting is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(S)(iii) because of one of the following (check one box):
 - The purpose of the use or disclosure of protected health information is not to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to identify any person for such purposes.
 - The purpose of the use or disclosure of protected health information is to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, or to identify any person for such purposes, but the reproductive health care at issue was not lawful under the circumstances in which it was provided.
- I understand that I may be subject to criminal penalties pursuant to 42 U.S.C 1320d-6 if I knowingly and in violation of HIPAA obtain individually identifiable health information relating to an individual or disclose individually identifiable health information to another person.

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: _____



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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:

Fax: 855-849-8457

New Patient **Fax:** 207-528-8071

Dental Records:

Fax: 855-933-2292

Email: dental@kvhc.org

FOR OFFICE USE ONLY

Receiving Employee: _____