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Medical Records Authorization

Office Use Only: □ Transfer □ Sending □ Receiving □ Ongoing □ Disclosure Recorded
Account #: ______ Provider: ______ Completed: ______

Katahdin Valley Health Center
PO Box 500
Patten, ME 04765
1-866-366-KVHC
Fax: (207) 528-8071
www.kvhc.org

Patient Information (Please Print)

Patient's Name: ______________________ DOB: ____________

Patient's Address: ______________________ City: ____________

State: ____________ Zip: ________ Phone: ______________________

Release Information I hereby authorize Katahdin Valley Health Center to:

□ **Release my records to:** □ **Request my records from:** □ **Communicate verbally with:**

Name/Facility: ____

Address: ______________________ City: ____________

State: ______ Zip: __________ Phone: ____________ Fax: ____________

Purpose of Request

□ Transferring Care □ Ongoing Treatment □ Verbal Communication □ Verification of Services

□ Legal Matters □ Personal Records □ Disability Claim □ Other: ____________

Information to be Released

□ Entire Medical Record

□ Summary of Medical History

□ Medication/Problem List

□ Other (please specify): ______________________________________

□ Exclusions (please specify): ______________________________________

By signing this authorization, I consent to the release of any and all medical information, unless specified under "exclusions" above. For purposes of this authorization, medical information may include confidential and sensitive information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health information. By signing this authorization, I acknowledge that I have the right to review my records prior to their disclosure. I understand that the review must be supervised.

*My consent to release these records is effective until ____________. I authorize future disclosures regarding these records to the same individuals or entities during this time period. **If no date is specified, the release will be effective for __one year__.***

I understand that:

- I may revoke all or part of this authorization at any time by notifying the facility or entity from which the records were requested, in writing, subject to the rights of anyone who received or disclosed information prior to receiving my revocation.
- 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 receives the information.
- I may have a copy of this form upon request.
- I may cross out any words on this form with which I disagree.
- 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

______________________________ ______________ ____________
(Signature of Patient, Parent, Legal Guardian, or Authorized Representative) (Relationship to Patient) (Date)

____
(Name of Patient, Parent, Legal Guardian, or Authorized Representative - Print)