SACOPEE VALLEY HEALTH CENTER
70 Main Street Porter, ME 04068
Phone (207) 625-8126 - Fax (207) 625-7820
www.svhc.org

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

A. **Patient's Name** ***(Please Print):***	**Date of Birth:** _____/_____/_____ Month Day Year
Address:	**Phone:** ( ) -

B. Permission to Share: I give my permission to share my individually identifiable health information, which may include protected or privileged information in written and/or verbal form.

From:	**To:**
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
FAX Number: _____	FAX Number: _____
Telephone Number: _____	Telephone Number: _____

C. Reason for Release of Records: _____

D. Information to be released for treatment dates: From _____/____/_____ through ____/____/_____

E. Documents to be released: Please check YES or No for <u>each</u> of the following options

YES NO	YES NO
☐ ☐ **Medical Records Abstract** (i.e. History & Physical, Operative/Procedure Reports, Clinical/Office Notes, All Diagnostic Test Results)	☐ ☐ Radiology Reports
☐ ☐ Optometry Records	☐ ☐ Laboratory Reports
☐ ☐ Dental Records	☐ ☐ Pathology Reports
☐ ☐ X-Rays/ X-Ray Reports (please specify): _____	☐ ☐ Entire Medical Record
	Other (please specify): _____

F. Privileged or Specifically Protected Information: Please check YES or No for <u>each</u> of the following question

YES NO	YES NO
☐ ☐ Alcohol or Drug Abuse Treatment	☐ ☐ HIV/AIDS diagnosis and/or treatment: I specifically give permission to share information in my record about my HIV/AIDS diagnosis and/or treatment information. Initial here to specifically authorize release _____.
☐ ☐ Sexually Transmitted Diseases	☐ ☐ Genetics Testing: I specifically give permission to share information in my record about my genetics testing. Initial here to specifically authorize release_____.
☐ ☐ Domestic Violence Victim's Counseling	
☐ ☐ Sexual Assault Victim Counseling	
☐ ☐ Communication between patient and social worker	
☐ ☐ Psychiatric Health- mental health information including communication between a patient and a Psychiatrist and licensed Psychologist	

G. I understand and agree that:

- The information which I authorize for release may be re-sent and no longer protected by federal privacy regulations
- I decline the opportunity to inspect or copy the information released
- This authorization is voluntary
- I may take back this authorization at any time by notifying the physician/hospital/clinic/organization from whom I am requesting this information, provided that the information has not already been released
- My questions about this authorization have been answered

H. This authorization expires <u>30 months</u> from the date it was signed OR as specified: ____/____/____

I. X _____ _____ <u>OR</u>
Patient's Signature Print Name

X _____ _____ _____
Signature of Person authorized to sign for patient Print Name Relationship to patient

Date: ____/____/_____ Time: ____ ____:____ ____ ○ a.m. ○ p.m.