KETTERING Health Network

# REQUEST FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient name: _____

Date of birth: _____ Phone: _____

Last four digits of social security #: _____ **Date of treatment:** _____

Specific facility needed: ❑ Kettering Health Network facility ❑ Kettering Physician Network physician office

❑ Other: _____

The purpose of this request is for:

❑ Continuity of care ❑ Legal matter ❑ Insurance ❑ MyChart App ❑ At the request of the individual

❑ Other: _____

I authorize **Kettering Health Network** to use or disclose the above named individual's health information as described below.

The type of information to be used or disclosed is as follows: *(check the appropriate boxes and include other information where indicated)*

❑ All reports ❑ Specify reports: _____

The information identified above may be used by or disclosed to the following:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Email: _____

***** *By providing Kettering Health Network my email address, I understand and accept the risks involved with the transmission of my medical documention. For questions, visit the link below. Due to size limitations, records may be mailed.*

**I understand that I will be charged a copy fee for copies not mailed directly to a health care provider. ORC 3701.742**

_____ _____

Signature of patient or legal representative Date

If signed by legal representative, relationship to patient: _____

Kettering Health Network
Release of Information Department
1 Prestige Place, Suite 540
Miamisburg, OH 45342
**Office:** (937) 762-1200 **Fax:** (937) 522-8444

***ketteringhealth.org/patientrelations/medicalrecords/***

**Request will be invalid if not filled out completely.**