Kettering HEALTH

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 facility ❑ Kettering Physician Network physician office

❑ Other _____

The purpose of this request is for:

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

❑ Other: _____

I authorize **Kettering Health** 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: **(address required)**

Name _____

Address _____

_____

Phone _____ Fax _____

Email _____

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

Preferred delivery:

❑ Mail

❑ Email

❑ MyChart

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

_____ _____

Signature of patient or legal representative Date

If signed by legal representative, relationship to patient _____

Kettering Health
Release of Information Department
1 Prestige Place, Suite 540 • Miamisburg, OH 45342
Office: (937) 762-1200 **Fax:** (937) 522-8444
Email: *ReleaseofInformation@ketteringhealth.org*

www.ketteringhealth.org/patientrelations/medicalrecords/

Request will be invalid if not filled out completely.