KETTERING Physician Network
KETTERING HEALTH NETWORK

Patient Contact Authorization Form

Please print all information requested in **BOLD**; then, sign and date the form at the bottom.

Patient Name: _____ **DOB**:_____

E-mail Address: _____

Address you would like your billing statements/office correspondence sent **IF OTHER THAN YOUR HOME ADDRESS**:

Address:_____ **City/State:**_____ **ZIP Code:** _____

Protected Health Information (PHI): I authorize my physician and/or their representative to disclose limited protected health information pertaining to me to the following individuals authorized by me to receive such PHI for the purposes of informing them of my general medical condition and diagnosis for treatment, payment, and other needs related to my healthcare.

Name: _____ **Relationship**: _____ **Phone**: _____

Name: _____ **Relationship**: _____ **Phone**: _____

Legal Documents: Please complete the information below and **provide the legal documents**, if applicable. These will be entered in the electronic health record:

Guardianship/Custody: Name: _____ **Phone**: _____

Healthcare Power of Attorney: Name: _____ **Phone:** _____

Preferred Method of Communication: How would you like to receive information about your appointments, test results and other healthcare information:

- ☐ **Home phone:** _____
- ☐ **Mobile phone:** _____
- ☐ **Work phone:** _____
- ☐ **Other Family Member: Name**: _____ **Phone**: _____

- *Disclosures made under this authorization may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.*
- *Termination of authorization: This authorization will remain in effect until terminated by me, my legally authorized personal representative or another individual(s) authorized to act on my behalf by court order or law.*
- *I am responsible for any changes or updates related to the individuals I list on this form as well as the contact information associated with those individuals.*
- *I have the right to revoke this authorization by submitting a written request.*

_____ _____

Signature of the Patient or Legal Representative **Date**