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 medical centers

❑ Kettering Health Medical Group physician office

RECORDS REQUESTED FROM PHYSICIAN'S OFFICE BELOW:

Name _____

Address _____

Phone _____ Fax _____

Email _____

❑ Other _____

Medical Information Requested:

❑ Complete medical record ❑ Imaging/EKG ❑ History and physical ❑ Other_____

❑ Demographic sheet ❑ Immunization record ❑ Laboratory results _____

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.

The information identified above may be used by or disclosed to the following: ***(address required)***

Name _____

Address _____

Phone _____ Fax _____

Email _____

Preferred delivery:

❑ **Mail**

❑ **Email**

❑ **MyChart**
(HOSPITAL RECORDS ONLY)

**** 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.***

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
(FOR HOSPITAL RECORDS)
1 Prestige Place, Suite 540 • Miamisburg, OH 45342
Office: (937) 762-1200 **Fax:** (937) 522-8444
ReleaseofInformation@ketteringhealth.org

Kettering Health Medical Group
Medical Records
(FOR PHYSICIAN OFFICE RECORDS)
1827 Woodman Center Dr. • Kettering, OH 45420
Office: (937) 531-7101 **Fax:** (937) 522-7771
KPNabstraction&ROI@ketteringhealth.org

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