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: ______________________________

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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

Request will be invalid if not filled out completely.

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