KETTERING Physician Network
KETTERING HEALTH NETWORK

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Social Security #: _____

Date of Treatment: _____

The purpose of this request is for:

❑ Continuity of care ❑ Legal matter ❑ Insurance ❑ At the request of the individual ❑ Selecting new provider

The person identified above, do hereby authorize the release of my medical information, as indicated between the following parties:

FROM PHYSICIAN RECORDS REQUESTED:

Name: _____

Address: _____

Phone: _____

Fax: _____

TO LOCATION TO SEND REQUESTED RECORD:

Name: _____

Address: _____

Phone: _____

Fax: _____

Medical Information Requested:

❑ Completed Medical Record
❑ Demographic Sheet
❑ Imaging/EKG
❑ Other: _____
❑ Immunization Record
❑ History and Physical
❑ Laboratory Results

I understand that the information in my health record may include information relating to sexually transmitted disease **(STD)**, acquired immunodeficiency syndrome **(AIDS)**, or human immunodeficiency virus **(HIV)**. It may also include information about **behavioral or mental health services**, and **treatment of alcohol and drug abuse**.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the **Release of Information Department, One Prestige Place, Suite 540, Miamisburg, OH or fax (937) 522-8444**. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization shall remain in effect for one year from the date of my signature below unless I specify an earlier expiration date in the space _____.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

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

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____

Signature of patient or legal representative Date

If signed by legal representative, relationship to patient: _____