KETTERING Physician Network

KETTERING HEALTH NETWORK

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Patient Telephone Number _____ Social Security Number _____

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:

☐ Complete 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 Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. 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. ORD 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 _____