KETTERING Health Network

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Office: (937) 762-1200 Fax: (937) 522-8444

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Social Security #: _____

Date of Treatment: _____

Specific Facility Needed: ❑ KMC ❑ GVMC ❑ SVMC ❑ SMC ❑ GMH ❑ FHH ❑ Soin ❑ KBMC

The purpose of this request is for: ❑ Continuity of care ❑ Legal matter ❑ Insurance ❑ MyChart
❑ 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):

- ❑ Face Sheet
- ❑ Consultation
- ❑ Pathology Report
- ❑ EKG
- ❑ ED Report
- ❑ Other: _____
- ❑ Discharge Summary
- ❑ Progress Notes
- ❑ Laboratory
- ❑ Physician Orders
- ❑ Outpatient Report
- ❑ History & Physical
- ❑ Operative Report
- ❑ Imaging Report
- ❑ Nursing Notes
- ❑ Pertinent Information

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**.

The information identified above may be used by or disclosed to the following:

Name: _____

Address: _____

_____

Phone: _____

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.

I understand that 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: _____