REQUEST FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________ Date of Birth: ______________

Phone Number: ______________________ Social Security #: ______________

Date of Treatment: ______________________

Specific Facility Needed:

- ❑ Kettering Medical Center ❑ Grandview Medical Center ❑ Southview Medical Center
- ❑ Sycamore Medical Center ❑ Greene Memorial Hospital ❑ Fort Hamilton Hospital
- ❑ Soin Medical Center ❑ Troy Hospital ❑ Kettering Behavioral Medicine Center
- ❑ Other: ______________

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
- ❑ Discharge Summary
- ❑ Progress Notes
- ❑ Laboratory
- ❑ Physician Orders
- ❑ Outpatient Report
- ❑ History & Physical
- ❑ Operative Report
- ❑ Imaging Report
- ❑ Nursing Notes
- ❑ Pertinent Information
- ❑ Other: ______________

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

Name: ______________________

Address: ______________________

____

Phone: ______________________

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: ______________________

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