KETTERING Physician Network
KETTERING HEALTH NETWORK

REQUEST 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 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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Release of Information Department
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