KETTERING Health Network

REQUEST FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Social Security #: _____

Date of Treatment: _____

Specific Facility Needed:

❑ Kettering ❑ Grandview ❑ Southview ❑ Sycamore ❑ Greene ❑ Fort Hamilton ❑ Soin
❑ Kettering Behavioral ❑ 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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