Kettering HEALTH

Patient Contact Information

Please print all information requested in **BOLD**, then sign and date form at the bottom.

Patient name _____ **Date of birth** _____

Email address _____

Purpose of Request: I authorize my physician and/or their representative to disclose limited protected health information, pertaining to me, to the following individual(s) who is authorized by me to receive such PHI for the purposes of informing them of my general medical condition and diagnosis for treatment, payment, and other needs related to my healthcare:

Name	**Relationship**	**Phone**

- Termination of authorization: This authorization will remain in effect until terminated by me, my legally authorized personal representative or another individual(s) authorized to act on my behalf by court order or law.
- I am responsible for any changes or updates related to the individuals I list on this form, as well as, the contact information associated with those individuals.
- Right to revoke: I have the right to revoke this authorization by submitting a written request.

Please print the address you would like your billing statements and/or correspondence from our office sent, **IF OTHER THAN YOUR HOME**:

Address	City/State	Zip code

Please print the telephone number(s) where you would like to receive calls about your appointments, test results and other healthcare information:

Home: Leave message: ❑ Y ❑ N	**Mobile: Leave message: ❑ Y ❑ N**	**Office/Work: Leave message: ❑ Y ❑ N**

Disclosures made under this authorization may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

Signature of patient or legal representative	Date