Kettering HEALTH

REQUEST FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient name _____

Date of birth _____ Phone _____

Last four digits of social security # _____ **Date of treatment required** _____

Specific Facility Needed:

❑ Kettering Health medical centers

Facility name _____

Address _____

❑ Kettering Health Medical Group physician office

Physician's name _____

Address _____

❑ Other _____

The purpose of this request is for:

❑ Continuity of care ❑ Legal matter ❑ Insurance ❑ At the request of the individual

❑ Other _____

Medical Information Requested:

❑ Complete medical record
❑ Demographic sheet
❑ Imaging/EKG
❑ Immunization record
❑ History and physical
❑ Laboratory results
❑ Other _____

I authorize Kettering Health to use or disclose the above requested information be sent to the requestor/provider below. The information identified above may be used by or disclosed to the following: ***(address required)***

Name _____

Address _____

Phone _____ Fax _____

Email _____

*** *By providing Kettering Health my email address, I understand and accept the risks involved with the transmission of my medical documentation. For questions, visit the link below. Due to size limitations, records may be mailed.***

Preferred delivery:

❑ **Mail**-($6.50 CD/$18.50 paper)
❑ **Email**-(no charge)
❑ **Fax**-(75 page limit)
❑ **MyChart**-(no charge)

I understand that I will be charged a copy fee for copies not mailed directly to a healthcare provider. ORC 3701.742

_____ _____

Signature of patient or legal representative Date

If signed by legal representative, relationship to patient _____

Kettering Health and Kettering Health Medical Group
Release of Information Department
1 Prestige Place, Suite 540 • Miamisburg, OH 45342
Office: (937) 762-1200 **Fax:** (937) 522-8444
ReleaseofInformation@ketteringhealth.org

Request will be invalid if not completely filled out.