Kettering HEALTH

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient name _____

Date of birth _____ Phone _____

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

Specific facility or facilities information will be disclosed from:

❑ 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 _____

Information to be released:

❑ Complete medical record
❑ Emergency department reports
❑ Test results (lab, pathology, radiology)
❑ Immunization record
❑ Office visit
❑ History and physical
❑ Discharge summary
❑ Other _____

I, the undersigned, authorize Kettering Health to release the above requested information to the individual/organization below.

Name _____

Address _____

Phone _____ Fax _____

Email _____

Preferred delivery:

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

I, the undersigned, understand and acknowledge the requested health information could include information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions and/or alcohol/drug abuse. This authorization will expire one year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice to the Kettering Health Release of Information Department at the address below. Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether I sign this authorization. After my health information is released, my information may be redisclosed by the recipient and may no longer be protected by law. The recipient of my health information may be charged for the service of releasing medical information as per Ohio Revised Code 3701.741 and federal law, as applicable. There is no charge to send records directly to my health care provider for continuing care purposes.

_____ _____

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 110 • Miamisburg, OH 45342
Office: (937) 762-1200 **Fax:** (937) 522-8444
ReleaseofInformation@ketteringhealth.org

Request will be invalid if not completely filled out.