KETTERING Physician Network
KETTERING HEALTH NETWORK

REQUEST FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient name: _____

Date of birth: _____ Phone: _____

Last four digits of 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 ❑ Other: _____

The person identified above, do hereby authorize the release of my medical information, as indicated between the following parties:

PHYSICIAN/PRACTICE RECORD REQUESTED FROM:

Name: _____

Address: _____

Phone: _____

Fax: _____

LOCATION TO SEND REQUESTED RECORD:

Name: _____

Address: _____

Phone: _____

Fax: _____

Medical information requested:

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

If you prefer to have your information emailed to you, instead of mailed, please enter your email address below.

Email: _____

***** *By providing Kettering Physician Network my email address, I understand and accept the risks involved with the transmission of my medical documentation. Due to size limitations, records may be mailed.*

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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