



KETTERING HEALTH NETWORK

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Patient Telephone Number _____ Social Security Number _____

Date of Treatment _____

Specific Facility needed KMC GVMC SVH SH GMH FHH SOIN

The purpose of this request is for Continuity of care Legal matter Insurance 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).

- | | | |
|---|--|--|
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History & Physical |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Laboratory | <input type="checkbox"/> Imaging Report |
| <input type="checkbox"/> EKG | <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Nursing Notes |
| <input type="checkbox"/> ED Report | <input type="checkbox"/> Outpatient Report | <input type="checkbox"/> Pertinent Information |
| <input type="checkbox"/> Other _____ | | |

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

The information identified above may be used by or disclosed to the following:

Name _____

Address _____

Phone _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that this authorization shall remain in effect for one year from the date of my signature below unless I specify an earlier expiration date in the space _____.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

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

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Signature of patient or legal representative

Date

If signed by legal representative, relationship to patient _____

Kettering Health Network AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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OnBase Document Type: HIM ROI Authorization



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