



# KETTERING HEALTH NETWORK

## AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Telephone Number \_\_\_\_\_ Social Security Number \_\_\_\_\_

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).

Face Sheet	Discharge Summary	History & Physical
Consultation	Progress Notes	Operative Report
Pathology Report	Laboratory	Imaging Report
EKG	Physician Orders	Nursing Notes
ED Report	Outpatient Report	Pertinent Information
Other _____		
Date of Treatment _____		

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 \_\_\_\_\_  
\_\_\_\_\_

This information for which I am authorizing disclosure will be used for the following purpose:

My personal records \_\_\_\_\_ Sharing with other health care providers as needed \_\_\_\_\_  
Other (please describe): \_\_\_\_\_

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.

This authorization will expire (insert date or event): \_\_\_\_\_

If I fail to specify an expiration date or event prior to one calendar year, this authorization will expire one calendar year from the date on which it was signed.

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 \_\_\_\_\_