KETTERING Physician Network
KETTERING HEALTH NETWORK

# REQUEST FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Phone Number: _____ 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

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

**FROM PHYSICIAN RECORDS REQUESTED:**

Name: _____

Address: _____

Phone: _____

Fax: _____

**TO LOCATION TO SEND REQUESTED RECORD:**

Name: **Michigan Legal Copy catherine@mlcopy.com**

Address: **4121 Okemos Road, Suite 12**

Phone: **517-349-1700**

Fax: **517-349-1717**

Medical Information Requested:

❑ Completed Medical Record
❑ Demographic Sheet
❑ Imaging/EKG
❑ Other: _____
❑ Immunization Record
❑ History and Physical
❑ Laboratory Results

**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: _____

**Kettering Health Network**
**Release of Information Department**
One Prestige Places, Suite 540
Miamisburg, OH 45342
**Office:** (937) 762-1200
**Fax:** (937) 522-8444