KETTERING MEDICAL CENTER NETWORK

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

X Patient Name ______________________ X Date of Birth ______________

X Patient Telephone Number ______________ X Social Security Number ______________

I authorize **Kettering Medical Center Network** to use or disclose the above named individuals'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
- ☐ Consultation
- ☐ Pathology Report
- ☐ EKG
- ☐ ED Report
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Laboratory
- ☐ Physician Orders
- ☐ Outpatient Report
- ☐ History & Physical
- ☐ Operative Report
- ☐ Imaging Report
- ☐ Nursing Notes
- ☐ 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 **Examination Mgt Svcs Inc**
Address **654 Portage Trail Ste 4**
Cuyahoga Falls OH 44221
330-923-8255

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 Health Information Management Services 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 60 days, this authorization will expire 60 days 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 authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

X ______________________ X ______________
Signature of patient or legal representative — Date

If signed by legal representative, relationship to patient ______________________