AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name (First, Middle, Last):	Date of Birth:	Last Four of Social Security:
	____/____/_____	

Telephone Number:	Dates of Service to Release:
( )	From: _____ To: _____

Specific Reports to be Disclosed:

☐ Office Notes	☐ Operative Reports	☐ Laboratory Reports
☐ X-Ray Reports	☐ CT Reports	☐ MRI Reports
☐ Letters	☐ Sleep Study	☐ Other: _____

Purpose of Disclosure:

☐ Medical Treatment ☐ Disability ☐ Legal Reasons ☐ Personal ☐ Other: _____

Method of Receipt:

☐ Patient Portal ☐ Fax ☐ Mail ☐ Patient Pick-Up ☐ Other: _____

Recipient of Records:	
Name: _____	E-Mail: _____
Address: _____	Fax: _____
_____	Telephone: _____

This authorization shall be in force and effective until _____ (MM/DD/YYYY) at which times this authorization to use or disclose this protected health information expires.

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal regulations. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notice to Sarah Withers, 1810 Mackenzie Dr #2, Columbus, OH 43220. I understand that a revocation is not effective to the extent that Ohio ENT & Allergy Physicians has relied on the use or disclosure of the protected health information.

You may refuse to sign this authorization. Ohio ENT & Allergy Physicians will not condition your treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether you provider authorization for the requested use or disclosure.

Please fax or e-mail completed forms to 614-255-0558 or ROI@ohpin.com. Please call 614-827-0015 with questions.

_____

Signature of Patient or Legal Representative Date

_____

Printed Name of Legal Representative (If Applicable) Relationship to Patient