Ohio ENT & Allergy Physicians
SLEEP DIVISION

Protected Health Information Authorization Form

I hereby authorize the use or disclosure of my individually identifiable health information as described below. 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.

Patient Name:_____ DOB:_____

Requesting Physician Name:_____ Fax #:_____

Requesting information from:_____

_____
Specific information being requested (Please indicate approx. date)

____ X-Rays_____ ____ Labs_____

____CT Scan_____ ____OP Report_____

____MRI_____ ____Sleep Study_____

____Office Notes_____ ____Other_____

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

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.

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

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.

_____
Signature of patient or legal representative Date

_____
Printed name of legal representative (if applicable) Relationship to patient