



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:		
<input type="checkbox"/> Office Notes	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Laboratory Reports
<input type="checkbox"/> X-Ray Reports	<input type="checkbox"/> CT Reports	<input type="checkbox"/> MRI Reports
<input type="checkbox"/> Letters	<input type="checkbox"/> Sleep Study	<input type="checkbox"/> Other: _____
Purpose of Disclosure:		
<input type="checkbox"/> Medical Treatment <input type="checkbox"/> Disability <input type="checkbox"/> Legal Reasons <input type="checkbox"/> Personal <input type="checkbox"/> Other: _____		
Method of Receipt:		
<input type="checkbox"/> Patient Portal <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Patient Pick-Up <input type="checkbox"/> 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