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 re-disclosure 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 **Ohio ENT and Allergy Physicians Attn: Medical Records 974 Bethel Rd, Ste. A, Columbus Ohio 43214.** 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. **Mailing address for records listed above.**

_____

Signature of Patient or Legal Representative Date

_____

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