# HIPAA Compliant Authorization for Release of Protected Health Information

**Patient Information:**

Name: _____

Date of Birth: _____

Phone Number: _____

Address: _____

**Recipient of Records:**

I authorize the release of my medical records to:

Name/Organization: _____

Address: _____

Phone: _____

**Fax (Must be provided. We are unable to fax without a number):**

_____

**Releasing Provider:**

Records to be released from:

Provider Name: John Ryzenman, M.D.
Ohio Ear Institute
Ohio Hearing Institute

Address: 600 Taylor Station Road, Gahanna, OH 43230

**Information to Be Released:**

Please check all that apply (if available in EMR):

☐ Complete Medical Record – will be provided on an encrypted flash drive.
(This is a compilation of ALL records including your billing records – a **$35** processing fee is due prior to mailing your records via USPS, we will contact you to collect this fee via credit card)

Clinically relevant records (Can be faxed free of charge until Feb 1, 2026):

☐ Office Visit Notes

☐ Operative Reports

☐ Lab Results

☐ Imaging Reports

☐ Other (specify): _____

**Purpose of Disclosure:**

☐ Continuity of Care

☐ Legal

☐ Insurance

☐ Personal Use

☐ Other (specify): _____

(see reverse side)

**Expiration:**
This authorization will expire one year from the date signed.

**Patient Rights:**

- I understand that I may revoke this authorization at any time by submitting a written request to the provider listed above.
- Revocation will not apply to records already released in reliance on this authorization.
- I understand that once information is disclosed, it may no longer be protected by HIPAA.
- I understand that I am not required to sign this authorization to receive treatment.
- I can receive a free faxed copy of my clinically relevant records to the specified provider. They typically will not receive your billing records. This is not the "complete records."
- I understand that without returning this completed and signed document to the Ohio Ear Institute by scanning or sending digital images of it, then emailing it to **records@ohioear.com**, that my records cannot be released. Due to practice closure, after Oct 31, 2025, this could take several weeks to process.

**PLEASE NOTE:**

If you need your records faxed to a provider after February 1, 2026, contact Beth at (614) 759-8811 ext. 301, to make that request, and provide her this signed document.

**Signature:**

Patient Signature: _____

Date: _____

If signed by a personal representative, describe authority: _____