HIPAA Compliant Authorization for Release of Protected Health Information

Patient Information:

Name: _____
Date of Birth: _____
Phone Number (cell): _____
E-mail: _____
Address: _____

Recipient of Records:

I authorize the release of my medical records to (if to patient listed above, please check this box) ❑ :

Name/Organization: _____
Address: _____
Phone: _____
Fax: _____
(Number must be provided. We are unable to fax without it)

Releasing Provider:

Records to be released from:

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

Custodian of records address: 600 Taylor Station Road, Gahanna, OH 43230

Information to Be Released:

Due to practice closure October 2025, only complete medical records in PDF format are available

☐ Complete Medical Record – (provided on an encrypted flash drive, mailed to address above)
(This is a compilation of ALL records excluding 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). Billing records can be obtained free of charge from Mt Carmel billing department (614-546-4283)

Limited clinically relevant records (very limited number of pages can be faxed, if at all):

☐ Recent Office Visit Notes
☐ Recent Office tests
☐ Operative Reports (if applicable)

Purpose of Disclosure:

☐ Continuity of Care
☐ Legal
☐ Insurance
☐ Personal Use

(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 without returning this completed and signed document to the Ohio Ear Institute either by scanning or emailing digital images of it to **records@ohioear.com**, that my records cannot be released. Due to practice closure, on Oct 31, 2025, this could take several weeks to process once this form is received. If you are unable to send it to us digitally for faster processing, you can mail it to our custodian of records address listed on the prior page.

PLEASE NOTE:

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

Signature:

Patient Signature: _____

Date: _____

If signed by a personal representative, describe authority: _____