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): _____

Releasing Provider:

Records to be released from:

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

Address: 600 Taylor Station Road, Gahanna, OH 43230

Phone: 614-891-9190
Fax: 614-839-9174

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 billing records - $35 processing fee due)

Clinically relevant records (can be faxed):

☐ 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 my new provider, that I specified on the prior page. 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 via fax (614-839-9174), or scanned and emailed to **records@ohioear.com**, my records cannot be released. Due to practice closure after Oct 31th, 2025, this could take several weeks to process.

PLEASE NOTE:

If you need your records faxed to a provider after Nov 30th 2025, you will need to contact Beth at (614) 759-8811 ext. 301, to make that request, and provide them with this signed document.

Signature:

Patient Signature: _____

Date: _____

If signed by a personal representative, describe authority: _____