387 County Line Road West
Suite 115
Westerville, Ohio 43082
Phone: 614.891.9190
Fax: 614.839.9174

OHIO EAR INSTITUTE

# Authorization to Access or Release Protected Health Information

Patient:_____

Street Address:_____

City, State, Zip Code_____

Date of Birth_____

I hereby authorize **Ohio Ear Institute, LLC** to disclose the following personal health information about me as instructed below:

**Health information to be released**:
□ All Medical Records □ Clinical Reports □ Lab Reports □ X-ray Reports □ Inpatient Reports □ Surgery Reports
□ Other:_____

For the following time frame: From_____/_____/_____ to_____/_____/_____

**Name of the individual or entity to which the record should be disclosed**:

_____
_____
(Name of Physician/Health Care Facility/Other) (Phone)

_____
(Street Address)

**The purpose of the authorized use or disclosure of the information is a follows**:
□ Transfer of Records to New Treatment Provider.
□ Insurance Review or Dispute
□ Patient Request.
□ Legal Investigation
□ Other

This authorization will expire: _____/_____/_____. If I do not indicate a date, this will expire one (1) year from the date of my signature below. A photocopy of this authorization is as valid as the original.

I understand that I will be required to pay fees in advance for any copies requested as defined by the State of Ohio fee schedule.

I understand that I may revoke this authorization in writing at any time by sending a written revocation to **Ohio Ear Institute at: 387 County Line Road West, Suite 115, Westerville, Ohio 43082**. I understand that the revocation will not apply to information already released in response to this authorization.

I understand that this authorization is voluntary. I am confirming my authorization that the health care provider may use and/or disclose to the persons and/or organizations named in this form.

Signature of Patient or Representative_____
Date:_____

Relationship to Patient if Representative_____

Ohio Ear Institute Representative_____
Date:_____

**YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.**