OhioHealth

OhioHealth Ear, Nose & Throat Physicians

Authorization for Use or Disclosure of Protected Health Information (PHI)

AUTHORIZATION FOR PATIENT RECORDS

I hereby authorize my protected health information to be (check ✓ one from each row):

_____ **Disclosed TO:** _____ **Obtained FROM:** **OhioHealth Ear, Nose & Throat Physicians – Daniel Wade, DO**
1770 West Fourth Street
Mansfield, Ohio 44906
Telephone: (419) 520-2065
Fax: (419) 520-2066

_____ **Disclosed TO:** _____ **Obtained FROM:** **Name/Organization:** _____
Address: _____
City/State/Zip Code: _____
Telephone: _____ Fax: _____

INFORMATION REQUESTED

I hereby agree to this authorization and understand that it must contain Personally Identifiable Information and PHI as defined by HIPAA to ensure accuracy. I understand I have the right to limit the type of information released and to revoke this authorization by submitting a notice, in writing, to the privacy officer at MedCentral Ear, Nose, and Throat. Unless revoked, this authorization will expire one year from the date of signature or on the following date: _____.
I understand that a revocation is not effective to the extent that MedCentral Ear, Nose, and Throat has relied on the use or disclosure of the PHI. I understand that information disclosed may be subject to re-disclosure by the recipient and no longer be protected by federal or state law. MedCentral Ear, Nose, and Throat, is hereby released from any legal responsibility or liability for disclosure of the below information to the extent indicated and authorized herein. I understand that I have the right to inspect or copy the PHI to be used or disclosed as permitted under federal law, and I have the right to refuse to sign this authorization and/or receive a signed copy of this authorization.

❑ **ALL** medical records without exception, including clinical notes, lab testing (including HIV), mental health treatment, alcohol or drug abuse texting and treatment, sexually transmitted disease, consultation, secondary records, etc.

❑ **PARTIAL** medication records, which may include HIV testing, mental health treatment, alcohol or drug abuse testing and treatment, sexually transmitted disease, and other sensitive information. Please specify areas to be released:

❑ Lab reports	❑ EKGs	❑ Consultations	❑ Progress Notes
❑ Pathology reports	❑ PFTs	❑ Discharge Summaries	❑ Emergency Room Reports
❑ X-ray reports and films	❑ Procedures	❑ Operative Reports	❑ History/Physical Exams
❑ Cardiac Catheterizations	❑ Other (list)_____		

Treatment/admission dates to be included: _____

This PHI is being used or disclosed for the following purposes:

❑ Continuity of Care (Primary MD, Specialist, Hospital Care)
❑ Insurance company or other Third Party Reimbursement
❑ Pending legal action (Worker's Compensation, Disability, Liability, or Malpractice)
❑Other: _____

PATIENT INFORMATION

Patient or Representative Signature: _____ Date: _____

Patient Printed Full Name: _____

Patient Representative Printed Name: _____ Relationship: _____

Date of Birth: _____ Social Security Number: _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Additional Phone: (_____) _____