Ohio Head and Neck Surgeons, Inc.

Authorization to Name a Personal Representative

Patient's Full Name: _____

Date of Birth: _____

I hereby authorize that following people to be my Personal Representative:

_____

_____

_____

I understand that I may inspect or obtain a copy of the protected health information described by this authorization.

I understand that Ohio Head and Neck Surgeons, Inc. will not condition treatment, payment of (if applicable) enrollment in the health plan, or eligibility for benefits on my providing authorization for the requested use of disclosure and that I may refuse to sign this authorization.

I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Officer of Ohio Head and Neck Surgeons, Inc.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Expiration date or event: This authorization will expire at the end of the year.

Ohio Head and Neck Surgeons, Inc. provides authorization to you upon your request. This information will be disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains.

Ohio State law requires an individual or the individual's authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions.

_____ _____

Date **Signature of Patient**