



200 West Pearl Street • Findlay, OH 45840 • (419) 424-0380 • (800) 890-BVMA • www.bvma.com

Medical Record Release

To: _____
Enter provider/practice from where records are being requested

I, the undersigned, authorize the release of my medical records to (check specific provider(s) below):

BVMA Providers & FAX Numbers

- | | | | |
|--|--------------|--|--------------|
| <input type="checkbox"/> Jerome Beekman, M.D. | 419-427-1781 | <input type="checkbox"/> Michael Lindamood, M.D. | 419-427-1791 |
| <input type="checkbox"/> Bruce Bouts, M.D. | 419-427-1782 | <input type="checkbox"/> David Meier, M.D. | 419-427-1794 |
| <input type="checkbox"/> Michael Cairns, M.D. | 419-427-1793 | <input type="checkbox"/> Stephen Mills, D.O. | 419-427-1792 |
| <input type="checkbox"/> Sheri Clouse, CNP | 419-427-1782 | <input type="checkbox"/> Michael Otto, PA-C | 419-427-1794 |
| <input type="checkbox"/> Belinda Ernst, PA-C | 419-427-1796 | <input type="checkbox"/> Shanna Price, CNP | 419-427-1795 |
| <input type="checkbox"/> Mark Fox, M.D. | 419-427-1784 | <input type="checkbox"/> Angela Ray, M.D. | 419-427-1785 |
| <input type="checkbox"/> Gregory Gerschutz, M.D. | 419-427-1780 | <input type="checkbox"/> Gregory Ricketts, M.D. | 419-427-1790 |
| <input type="checkbox"/> Robert Heacock, M.D. | 419-427-1786 | <input type="checkbox"/> Chase Scarbrough, D.O. | 419-427-1888 |
| <input type="checkbox"/> Amy Hochstettler, PA-C | 419-427-1790 | <input type="checkbox"/> Rebecca Scarbrough, CNP | 419-427-1888 |
| <input type="checkbox"/> Randal Huff, M.D. | 419-427-1788 | <input type="checkbox"/> Leroy Schroeder, M.D. | 419-427-1795 |
| <input type="checkbox"/> Kelly Koenig, M.D. | 419-427-1783 | <input type="checkbox"/> Wendi Schworm, PA-C | 419-427-1795 |
| <input type="checkbox"/> Lisa Knor, M.D. | 419-427-1789 | <input type="checkbox"/> Rick Watson, M.D. | 419-427-1796 |
| | | <input type="checkbox"/> Amanda Williams, PA-C | 419-427-1792 |

Patient Name: _____

Patient Date of Birth: ____/____/____

Last 4 digits of Patient SSN: ____

Choose one option:

- Please FAX a copy of **ALL** records.
- Please FAX only the following information:

Date of visit or procedure with BVMA provider: ____/____/____

Patient's Signature: _____ Date: ____/____/____

The information requested will be used for the purposes of patient treatment only; unless otherwise requested by the patient.