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

Provider	FAX
☐ Bruce Bouts, M.D.	*419-427-1782*
☐ Michael Cairns, M.D.	*419-427-1793*
☐ Jeremy Clark, CNP	*419-427-1780*
☐ Mark Fox, M.D.	*419-427-1784*
☐ Gregory Gerschutz, M.D.	*419-427-1780*
☐ Robert Heacock, M.D.	*419-427-1786*
☐ Amy Hochstettler, PA-C	*419-427-1790*
☐ Randal Huff, M.D.	*419-427-1788*
☐ Kelly Koenig, M.D.	*419-427-1783*
☐ Lisa Knor, M.D.	*419-427-1789*
☐ Michael Lindamood, M.D.	*419-427-1791*
☐ David Meier, M.D.	*419-427-1794*
☐ Stephen Mills, D.O.	*419-427-1792*
☐ Katie Needler, CNP	*419-427-1794*
☐ Shanna Price, CNP	*419-427-1795*
☐ Angela Ray, M.D.	*419-427-1785*
☐ Gregory Ricketts, M.D.	*419-427-1790*
☐ Chase Scarbrough, D.O.	*419-427-1888*
☐ Rebecca Scarbrough, CNP	*419-427-1888*
☐ Leroy Schroeder, M.D.	*419-427-1795*
☐ Julie Schloemer, M.D.	*419-427-1885*
☐ Wendi Schworm, PA-C	*419-427-1795*
☐ Rick Watson, M.D.	*419-427-1796*
☐ Amanda Williams, PA-C	*419-427-1792*

Patient Name: ____

Patient Date of Birth: _____/_____/_____

Choose one option:

☐ Please FAX a copy of **ALL** records.

☐ Please FAX only the following information:

____

____

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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.