



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"/> Bruce Bouts, M.D.       | 419-427-1782 | <input type="checkbox"/> Carmela Osborne, M.D.   | 419-429-6484 |
| <input type="checkbox"/> Michael Cairns, M.D.    | 419-427-1793 | <input type="checkbox"/> Shanna Price, CNP       | 419-427-1795 |
| <input type="checkbox"/> Jeremy Clark, CNP       | 419-427-1780 | <input type="checkbox"/> Angela Ray, M.D.        | 419-427-1785 |
| <input type="checkbox"/> Mark Fox, M.D.          | 419-427-1784 | <input type="checkbox"/> Gregory Ricketts, M.D.  | 419-427-1790 |
| <input type="checkbox"/> Gregory Gerschutz, M.D. | 419-427-1780 | <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"/> Kelly Koenig, M.D.      | 419-427-1783 | <input type="checkbox"/> Leroy Schroeder, M.D.   | 419-427-1795 |
| <input type="checkbox"/> Lisa Knor, M.D.         | 419-427-1789 | <input type="checkbox"/> Julie Schloemer, M.D.   | 419-427-1885 |
| <input type="checkbox"/> David Meier, M.D.       | 419-427-1794 | <input type="checkbox"/> Wendi Schworm, PA-C     | 419-427-1795 |
| <input type="checkbox"/> Stephen Mills, D.O.     | 419-427-1792 | <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: \_\_\_\_/\_\_\_\_/\_\_\_\_

**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.**