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

*****Return to BVMA via FAX – (419) 427-1588*****

Authorization for Use and/or Disclosure of Health Information

I, the undersigned, hereby authorize Blanchard Valley Medical Associates to release my protected health information to:

Provider/Practice Name: _____

*Enter provider/practice **to where** records are to be sent **~OR~** list "SELF" if records to be released to patient directly*

Address: _____

_____

Fax #: _____

Patient Name: _____

Patient Date of Birth: _____/_____/_____

Choose one option:

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

☐ Please release only the following information:

_____

_____

_____

_____

This authorization shall be in force and effect until _____/_____/_____ at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Blanchard Valley Medical Associates, Privacy Officer, 200 West Pearl Street, Findlay, Ohio 45840. I understand that a revocation is not effective to the extent that Blanchard Valley Medical Associates has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Blanchard Valley Medical Associates will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights)
- Refuse to sign this authorization.

_____ _____/_____/_____

Signature or Patient or Personal Representative **Date**

_____

Name and Description of Personal Representative's Authority (if applicable)