



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

Authorization for Use and/or Disclosure of Health Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Phone: \_\_\_\_\_ Patient ID: \_\_\_\_\_ \*Office Use Only\*

I am the patient listed above, or the legally authorized representative of the patient listed above. I authorize the release of my medical records from:

Provider / Practice Name: \_\_\_\_\_

To:

- Emily Annesser, PA-C 419-427-1888
Bruce Bouts, M.D 419-427-1782
Michael Cairns, M.D 419-427-1793
Jeremy Clark, CNP 419-427-1780
Belinda Ernst, PA-C 419-427-1796
Mark Fox, M.D 419-427-1784
Gregory Gerschutz, M.D 419-427-1780
Alexandra Kaufman, P.A 419-427-1783
Kelly Koenig, M.D 419-427-1783
Lisa Knor, M.D 419-427-1789
David Meier, M.D 419-427-1794
Carmela Osborne, M.D 419-429-6484
Angela Ray, M.D 419-427-1785
Gregory Ricketts, M.D 419-427-1790
Ramsha Samra, D.P.M 419-427-1886
Chase Scarbrough, D.O 419-427-1888
Rebecca Scarbrough, CNP 419-427-1888
Julie Schloemer, M.D 419-427-1885
Wendi Schworm, PA-C 419-427-1795
Amy Sloan, ANP 419-427-1794
Rick Watson, M.D 419-427-1796
Amanda Williams, PA-C 419-427-1785

Description and Specific Dates of Service for Information Requested: \_\_\_\_\_

\*\*Include dates where appropriate below:

- Progress Notes
Lab Results
Radiology reports
All records, most recent 2 years
Other (specify):
Procedure Notes
Path Reports
Cardiac Reports

Purpose of Release/Disclosure: Continuation of medical care Transfer of care

Date of visit or procedure at Blanchard Valley Medical Associates: \_\_\_\_/\_\_\_\_/\_\_\_\_

- This authorization shall be in force for one year from the date below unless you specify an earlier termination.
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 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.

Signature of Patient or Personal Representative Print Name Date

If you are the legally authorized representative of the patient, describe the scope of your authority:

NOTE: Being listed on the patient's HIPAA authorization form does not establish legal representation or authority to act on behalf of the patient. Legal documentation is required to verify authorized access to records.

- Parent
Legally authorized representative
Other (specify and attach proof):
Durable Power of Attorney for Health Care
Personal representative of the Estate