

***I am the patient listed above, or the legally authorized representative of the patient listed above.***

***I request that protected health information be released to:***

* Provider/Practice Name:
* Self
* Legally Authorized Representative (name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Information Requested for: BVMA Provider name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

*\*\*Include dates where appropriate below:*

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Progress Notes

Lab Results Radiology reports All records, most recent 2 years

Other (specify):

**Fax completed form to:**

(419) 427-1797

200 West Pearl Street  Findlay, OH 45840  (419) 424-0380  [www.bvma.com](http://www.bvma.com/)

**Authorization for Use and/or Disclosure of Health Information**

Patient Name: DOB: / /

Patient Phone:

Patient ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Information should be delivered via:***

* Mail to the above address  Fax:  Pick-up by:
* Encrypted email: (address)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other method: (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*\***ID required for records picked up**\*\*

*Address (if mailing records):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Fax #:*

*Phone #:*

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Procedure Notes

Path Reports EKG/Echo/Stress Reports

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***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.*

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

**Signature of Patient or Personal Representative Print Name**

 / /

**Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_

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)

I **understand that I have the right to:**

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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.

Other (specify):

* Substantiation of payment/claims

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Personal use

Transfer of care

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Continuation of medical care

Legal use

***Purpose of Release/Disclosure:***