200 West Pearl Street ● Findlay, OH 45840 ● (419) 424-0380 ● (800) 890-BVMA ● 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:

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

Description and Specific Dates of Service for Information Requested: ___________________________

***Also include dates where appropriate below:*

☐ Progress Notes _____________________ ☐ Procedure Notes _____________________

☐ Lab Results ________________________ ☐ Path Reports ________________________

☐ Radiology reports ___________________ ☐ EKG/Echo/Stress Rpts _________________

☐ All records, most recent 2 years

☐ Other (specify): ____

____

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. You must submit a new authorization form after the expiration date to continue the authorizations. Please list the date of expiration if earlier than one year from the signature date below: _____/_____/_____
- 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.

____ _____/_____/_____

Signature or Patient or Personal Representative **Date**

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

****Attach necessary proof****

☐ Parent ☐ Durable Power of Attorney for Health Care

☐ Legally authorized representative ☐ Personal representative of the Estate

☐ Other (specify and attach proof): ____