Fax completed form to:
(419) 427-1797

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 request that protected health information be released to:

☐ Provider/Practice Name: ____
☐ Self
☐ Legally Authorized Representative (list name): ____
Address (if mailing records): ____
____
Phone #: __________________________ *Fax #:* ___________________________

Information should be delivered via:
☐ Mailed to the above address ☐ Fax: ________________ ☐ Picked-up by: _____________________
Identification is required for picked-up records

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 ☐ Personal use ☐ Substantiation of payment/claims
☐ Legal use ☐ Transfer of care
☐ Other (specify): ____

- 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**

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): ____