



## Blanchard Valley Medical Practices Authorization to Release Medical Records

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### Name of Medical Office or Physician(s) you are requesting records

Patient Name: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

#### 1. I hereby authorize the use or disclosure of personal health information about me as described below.

Indicate fully the information that is the subject of this authorization and which will be used or disclosed as set forth below:

All Medical Records – Date(s) of Service \_\_\_\_\_

Family Practice Only – Date(s) of Service \_\_\_\_\_

OB Records Only – Date(s) of Service \_\_\_\_\_

Shot Records – Date(s) of Service \_\_\_\_\_

Growth Chart – Date(s) of Service \_\_\_\_\_

Lab Testing – Date(s) of Service \_\_\_\_\_

X-rays/MRI/CT Scan Testing – Date(s) of Service \_\_\_\_\_

Progress/Dictation Notes – Date(s) of Service \_\_\_\_\_

Other, specify needed information and date(s) of Service \_\_\_\_\_

#### 2. Select one of the following:

Blanchard Valley Medical Practices may disclose the information described above to the following:

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Fax Number \_\_\_\_\_

The following entity may disclose my health information as described above to Blanchard Valley Medical Practices:

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Fax Number \_\_\_\_\_

#### 3. The purpose of the authorized use or disclosure of the information described above is as follows:

At the request of the above stated patient

Continuing Care

Transferring care

Fundraising

Pending legal action

Other (Specify) \_\_\_\_\_

Research Study

Marketing: Indicate whether Blanchard Valley Medical Practices will receive any remuneration or payment from a third party as a result of the marketing: \_\_\_\_\_

4. I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization I am authorizing the release of such information unless specified otherwise above.

5. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.





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**6.** As described in the Notice of Privacy Practices of Blanchard Valley Medical Practices, I understand that I may revoke this authorization in writing at any time by sending a written revocation to BVHS Privacy Officer, 1900 South Main Street, Findlay, OH 45840. I understand the revocation will not apply to information that has already been released in response to the authorization.

**7. This authorization will remain valid for one year from today's date or:**

At an earlier date; please specify: \_\_\_\_\_

End of research study (applicable only if the authorization is for a research study or for creation and maintenance of a research database or research repository)

**8.** I understand that I am not required to sign this authorization form and that BVMP will not condition the provision of treatment or payment to me on the signing of this authorization, except that BVMP may condition the provision of research-related treatment to me on the signing of this authorization for the use or disclosure of my personal health information for such research. BVMP may also condition the provision of health care to me that is solely for the purpose of creating protected health information for disclosure to a third party on the signing of this authorization.

**9. Please specify how the information should be disclosed (if applicable):**

Review record

Copy and pick up

Mail to patient address

Mail to address specified in Section 2

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Patient Name (Please Print)

Name of patient's legal representative, if applicable

Relationship to Patient

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Signature of patient or legal representative

Date \_\_\_\_\_ Time \_\_\_\_\_

**Office Use Only:**

Employee Initials: \_\_\_\_\_

Date Completed: \_\_\_\_\_

Mailed     Faxed     Patient to pick up

Provide a copy of this signed form to the patient

