BLANCHARD VALLEY MEDICAL ASSOCIATES
200 WEST PEARL STREET
FINDLAY, OHIO 45840
PHONE: 419-427-1593
FAX: 419-427-1595

MEDICAL RECORD RELEASE

TO: _____

I, the undersigned, authorize the release of my medical records to:

_____ Michael L. Cairns, MD _____ J. Marvin Rower, MD

INFORMATION REQUESTED: _____

_____

_____

_____

Date of admission or procedure done: _____

Patient's Name: _____

Date of Birth: _____ Social Security Number: _____

Patient's Signature: _____

Date: _____

Witness: _____

The information requested will be used for purposes of patient treatment only unless otherwise requested by the patient.