

**BLANCHARD VALLEY MEDICAL ASSOCIATES**

**200 WEST PEARL STREET**

**FINDLAY, OHIO 45840**

**PHONE: 419-424-0380**

**MEDICAL RECORD RELEASE**

TO: \_\_\_\_\_

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

- |   |   |
|---|---|
| _____ Jerome F. Beekman, MD fax 419-427-1781  | _____ Michael L. Cairns, MD fax 419-427-1793    |
| _____ Bruce A. Bouts, MD fax 419-427-1782     | _____ Gregory P. Gerschutz, MD fax 419-427-1780 |
| _____ Mark R. Fox, MD fax 419-427-1784        | _____ Robert L. Heacock, MD fax 419-427-1786    |
| _____ James A. Gideon, MD fax 419-427-1783    | _____ Randal E. Huff, MD fax 419-427-1788       |
| _____ Gary E. Hirschfeld, MD fax 419-427-1787 | _____ Michael W. Lindamood, MD fax 419-427-1791 |
| _____ Lisa M. Knor, MD fax 419-427-1789       | _____ Stephen D. Mills, DO fax 419-427-1792     |
| _____ David J. Meier, MD fax 419-427-1794     | _____ Gregory A. Ricketts, MD fax 419-427-1790  |
| _____ Angela Willeke Ray, MD fax 419-427-1785 | _____ Rick D. Watson, MD fax 419-427-1796       |
| _____ Leroy L. Schroeder, MD fax 419-427-1795 |   |

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.