

**BLANCHARD VALLEY MEDICAL ASSOCIATES**  
**AUTHORIZATION FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION**

I, \_\_\_\_\_, hereby authorize Blanchard Valley Medical Associates to (check those that apply):  
\_\_\_\_\_ use the following protected health information, and/or

\_\_\_\_\_ disclose the following protected health information to:

Information (specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.): \_\_\_\_\_

This protected health information is being used or disclosed for the following purposes: \_\_\_\_\_

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 redisclosure 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 of Patient or Personal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name of Patient or Personal Representative**

\_\_\_\_\_  
**Description of Personal Representative's Authority**

