Blanchard Valley Medical Associates

200 West Pearl Street ● Findlay, OH 45840 ● (419) 424-0380 ● www.bvma.com

Fax completed form to:
(419) 427-1797

Authorization for Use and/or Disclosure of Health Information

Patient Name: _____ DOB: _____/____/_____

Patient Phone: _____ Patient ID: _____

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 (name): _____

*Address(if mailing records anywhere)*_____

Phone #: _____ *Fax #:* _____

Information should be delivered via: ****ID required for records picked up****

☐ Mail to the above address ☐ Fax: _____ ☐ Pick-up by: _____

☐ Encrypted email: (address)_____

☐ Other_____

Information Requested from ALL BVMA Providers OR Provider name: _____

***Include dates where appropriate below:*

☐ Progress Notes _____ ☐ Procedure Notes _____

☐ Lab Results _____ ☐ Path Reports _____

☐ Radiology reports _____ ☐ EKG/Echo/Stress Reports_____

☐ 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 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)

_____ _____ _____/_____/_____

Signature of Patient or Personal Representative **Print Name** **Date**

If you are the legally authorized representative of the patient, please describe the scope of your authority below: ***Note:*** *Being listed on the patient's HIPAA authorization form does not, by itself, grant legal authority or establish legal representation.*

☐ Parent ☐ Durable Power of Attorney for Health Care

☐ Legally authorized representative ☐ Personal representative of the Estate

☐ Other (specify and attach proof): _____