Blanchard Valley HEALTH SYSTEM

Authorization to Release Patient Information

Patient Name: _____ Maiden Name: _____

Date of Birth: _____ Phone Number: _____ SSN: _____ (Last four digits)

Patient Address: _____
Street City State Zip Code

I hereby authorize the use or disclosure of protected health information about the above individual as described below.

1. The protected health information to be DISCLOSED from or used by the following entity:
   - ☐ Blanchard Valley Health System
   - ☐ Other Hospital/Physician Office: _____

   Address: _____
   Street City State Zip Code

   Phone Number: _____ Fax Number: _____

2. Person/Provider/Organization authorized to RECEIVE or use the information:
   - ☐ Patient (proceed to Section 3)
   - ☐ Other Recipient Name: _____

   Address: _____
   Street City State Zip Code

   Phone Number: _____ Fax Number: _____

3. The purpose of the authorized use or disclosure of the information is as follows:
   - ☐ At the request of the above stated patient (personal use) ☐ Continuity of Care/Treatment ☐ Insurance
   - ☐ Legal Use ☐ Research Study ☐ Fundraising
   - ☐ Other: (specify) _____
   - ☐ Marketing: Indicate whether Blanchard Valley Health System will receive any remuneration or payment from a third party as a result of the marketing: _____

4. Dates of Service to be disclosed or used: (From): _____ (To): _____

5. Records to be disclosed or used:
   - ☐ Pertinent Summary (includes all * items)
   - ☐ * History and Physical ☐ * Operative/Procedure Report ☐ Office Visit Notes
   - ☐ * Discharge Summary ☐ * Diagnostic/Radiology Reports ☐ Entire Record **
   - ☐ * Emergency Room Report ☐ * Lab Results ☐ Other: _____
   - ☐ * Consultation Report ☐ * Pathology Reports _____

6. 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.

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

** According to Blanchard Valley Health System's Notice of Privacy Practices and Designated Record Set.

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8. As described in the Notice of Privacy Practices of Blanchard Valley Health System, 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.

9. 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)

10. I understand that I am not required to sign this authorization form and that BVHS will not condition the provision of treatment or payment to me on the signing of this authorization, except that BVHS 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. BVHS 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.

11. Information should be disclosed via:

☐ Mail to address specified in Section 2
☐ Fax to number specified in Section 2
☐ Mail to patient address
☐ Pick up by: _____(ID is required for pick up)
☐ Pick up: Paper Records ☐ Pick up: CD
☐ On-site Review – by appointment only, minimum two business days' notice, call 419-423-5330
☐ MyHealth Patient Portal Upload
☐ Secure, Encrypted Email to: _____
☐ Unencrypted Email to: _____
I acknowledge the risks associated with information sent via email which could lead to misdirection or interception in transmission.

X_____ _____ _____
Signature of patient or legal representative | Date | Time

If you are the legal representative of the patient, describe the scope of your authority:

☐ Parent ☐ Durable Power of Attorney for Health Care (attach proof)
☐ Legally Authorized Representative (attach proof) ☐ Personal Representative of the Estate (attach proof)
☐ Other (specify and attach proof) _____

X_____ _____ _____
Signature of BVHS representative (optional) | Date | Time

Submit authorization to one of the following:

1. Health Information Services
   Blanchard Valley Health System
   1900 S. Main Street
   Findlay, OH 45840
2. Fax: 419-423-5100
3. Email: ReleaseOfInformation@bvhealthsystem.org