

Photo ID checked:  Driver's License  Other \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I hereby authorize the use or disclosure of personal health information about me as described below.

1. Indicate fully the information that is the subject of this authorization and which will be used or disclosed as set forth below:

- History and Physical/Assessment – Date(s) of Service \_\_\_\_\_
- Discharge Summary – Date(s) of Service \_\_\_\_\_
- Lab tests – Date(s) of Service \_\_\_\_\_
- Radiology Reports – Date(s) of Service \_\_\_\_\_
- Entire Record – Date(s) of Service \_\_\_\_\_
- Pathology Slides and Materials \_\_\_\_\_
- Other, specify needed information and date(s) of service: \_\_\_\_\_  
\_\_\_\_\_

2. Select one of the following:

- Blanchard Valley Health System may disclose the information described above to (specify address, if applicable):  
\_\_\_\_\_  
\_\_\_\_\_
- The following person(s) or group of persons employed or working for Blanchard Valley Health System may use my health information as described above:  
\_\_\_\_\_  
\_\_\_\_\_
- The following entity may disclose my health information as described above to Blanchard Valley Health System:  
\_\_\_\_\_

3. The purpose of the authorized use or disclosure of the information described above is as follows:

- At the request of the above stated patient  Pending legal action
- 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. 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
- 5. 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.
- 6. 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.
- 7. 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)
- 8. 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.
- 9. Please specify how the information should be disclosed (if applicable):
  - Review record
  - Copy and pick up
  - Mail to patient address
  - Mail to address specified in Section 2

\_\_\_\_\_  
**Patient Name (Please Print)**

\_\_\_\_\_  
**Name of patient's legal representative, if applicable**

\_\_\_\_\_  
**Relationship of patient's legal representative to patient or statement of authority**

\_\_\_\_\_  
**Signature of patient or legal representative**

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

\_\_\_\_\_  
**Time**

\_\_\_\_\_  
**Signature of BVHS representative**

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

\_\_\_\_\_  
**Time**

***Provide a copy of this signed form to the patient***

