Blanchard Valley HEALTH SYSTEM

FOR USES & DISCLOSURES OF PATIENT INFORMATION

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: _____

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

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HEALTH SYSTEM

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**

Signatures must be notarized if not submitting form in person. Send notarized form to BVHS HIS, 1900 S. Main St., Findlay OH 45840 or by fax to 419-423-5100.

STATE OF OHIO
(COUNTY OF _____) SS

On this_____day of_____, 20___, before me, the undersigned Notary Public, personally appeared and, proved to me on the basis of satisfactory evidence to be the person whose name is subscribed above, and acknowledged that he/she executed it.

Witness my hand and official seal.

_____
Notary Public