Blanchard Valley Medical Practices Authorization to Release Medical Records

_____

Name of Medical Office or Physician(s) you are requesting records

Patient Name: _____

Patient's Address:_____

Date of Birth: _____ **Phone #**: _____ **Social Security #:** _____

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

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

☐ All Medical Records – Date(s) of Service _____

☐ Family Practice Only – Date(s) of Service _____

☐ OB Records Only – Date(s) of Service _____

☐ Shot Records – Date(s) of Service _____

☐ Growth Chart – Date(s) of Service _____

☐ Lab Testing – Date(s) of Service _____

☐ X-rays/MRI/CT Scan Testing – Date(s) of Service _____

☐ Progress/Dictation Notes – Date(s) of Service _____

☐ Other, specify needed information and date(s) of Service _____

2. Select one of the following:

☐ Blanchard Valley Medical Practices may disclose the information described above to the following:

Name_____

Address_____

Phone _____

Fax Number_____

☐ The following entity may disclose my health information as described above to Blanchard Valley Medical Practices:

Name_____

Address_____

Phone _____

Fax Number_____

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
☐ Transferring care
☐ Pending legal action
☐ Research Study
☐ Continuing Care
☐ Fundraising
☐ Other (Specify)_____
☐ Marketing: Indicate whether Blanchard Valley Medical Practices 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 re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

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6. As described in the Notice of Privacy Practices of Blanchard Valley Medical Practices, 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 60 days 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 BVMP will not condition the provision of treatment or payment to me on the signing of this authorization, except that BVMP 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. BVMP 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 to Patient**

_____	_____	_____
Signature of patient or legal representative	**Date**	**Time**

Office Use Only:

Employee Initials:_____ Date Completed:_____ ☐Mailed ☐Faxed ☐Patient to pick up

Provide a copy of this signed form to the patient