BLANCHARD VALLEY PEDIATRICS, INC.
Authorization for Disclosure of Health Information

Patient Name: _____DOB: _____

Address: _____

City: _____ State: ____ Zip: _____ Phone: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

3. The type and amount of information to be used or disclosed is as follows:
   _____Complete health records _____Lab results/x-ray reports
   _____Physical exam _____Consultation reports
   _____Immunization record
   _____Other (please specify): _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). It may also include information about behavior or mental health services and treatment for alcohol and drug abuse.

5. *This information may be disclosed to and used by the following individual or organization:*

BLANCHARD VALLEY PEDIATRICS, INC.
1818 CHAPEL DRIVE, SUITE D
FINDLAY, OH 45840
419-424-1922 (TELEPHONE)
419-424-1927 (FAX)

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information manager. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
7. If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. Questions about disclosure of my health information may be directed to the Privacy Officer for Blanchard Valley Pediatrics, Inc.

_____ _____
Signature of patient or legal representative **Signature of witness**

_____
Relationship to patient

Date: _____ **Date:** _____