



Henry County Family Physicians Inc.

Kip A. Bidwell, M.D.
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105 East Street
P. O. Box 94
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Phone: 419-533-6507
Fax: 419-7012

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P.O. Box 52
Holgate, OH 43527
Phone: 419-264-5800
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, _____/_____/_____, authorize
Print First Middle Initial Maiden Last Date of Birth

Physician: _____
Physician Obtaining Records From

Address: _____

To Release the following PHI from _____ to _____

- | | |
|--------------------------|---------------------|
| _____ All Records | _____ Lab Reports |
| _____ Office Visit Notes | _____ X-Ray Reports |
| _____ Hospital Reports | _____ Other _____ |

To: _____ Dr. Bidwell _____ Dr. Fritz _____ Dr. Knipe
_____ Dr. McMaster _____ Julie Thomas, CNP

Send Records to: **Henry County Family Physicians** or Fax to: **419-533-7012**
105 East Street, P.O. Box 94
Liberty Center, OH 43532

Consent:

I authorize the release of all information indicated, and I am aware that the records release may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol use/abuse, HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome). This authorization is valid for 90 days. It may be revoked by the signer. I understand that I am responsible for any charges associated with copying these records. I understand that it may take up to 10 business days to complete the record transfer. The use of this information for any other use than the stated purpose is prohibited. This information is for the use of the designated recipient only and cannot be provided to any other agency.

Signature of Patient, Parent, Guardian, or Patient Representative (circle one):

_____ Date: _____

Witness Signature: _____ Date: _____