



# Henry County Family Physicians Inc.

**Kip A. Bidwell, M.D.**  
**Stephen M. Knipe, M.D.**  
**Julie Thomas, DNP, RN, CNP**

**Melinda S. Fritz, M.D.** (affiliated with Henry County Hospital)  
**Anna M. McMaster, M.D.**

1600 E. Riverview Ave.  
Suite 101  
Napoleon, OH 43545  
Phone: 419-592-8774  
Fax: 419-592-4103

105 East Street  
P. O. Box 94  
Liberty Center, OH 43532  
Phone: 419-533-6507  
Fax: 419-7012

106 North Wilhelm  
P.O. Box 52  
Holgate, OH 43527  
Phone: 419-264-5800  
Fax: 419-264-5851

## 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: **419-592-4103**  
**1600 E. Riverview Ave, Suite 101**  
**Napoleon, OH 43545**

### 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: \_\_\_\_\_