ONE
4449 Easton Way, 2nd Floor
Columbus, OH 43219
T: (614) 934-1700 F: (855) 919-6128
www.onehealthoh.com

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____

I hereby authorize the ____disclosure ____request ____exchange of information from the following entity:

Name/ Organization: _____

Address: _____

_____

Phone: _____ Fax: _____

Protected Health Information requested: (Patient should initial each item)

_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan/Summary
_____ Medication List
_____ Psychotherapy Notes
_____ Last **3** treatment notes/encounters
_____ Labs/genetic testing
_____ Discharge Summary
_____ Demographic information
_____ Other: _____

Purpose of Disclosure:

_____ Continuity of Care
_____ Work/ School
_____ Collateral
_____ Legal
_____ Disability
_____ Other: _____

1. This release of information expires one year from the last date of treatment unless specified here:
   _____
2. I can revoke this release at any time by submitting a written request to ONE health at the address listed above.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.
4. I understand that I can refuse to sign this release of information.

Signature: _____ Date: _____

Patient Name: _____ Relation to Patient: _____

Name of Guardian/Legal representative: _____