ONE
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Columbus, OH 43219
T: (614) 745-0306 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
____ Medical 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: _____