One Health

RECORD RELEASE or REQUEST AUTHORIZATION TO USE AND DISCLOSE HEAL TH INFORMATION

Patient's Name: First _____ Middle _____ Last _____
Home Address: _____
Home Telephone: _____
Date of Birth (MM/DD/YYYY): _____

SPECIFIED INFORMATION To _____ OR _____ (CIRCLE WHICH)

The information that may be released or requested (mark which) under the authorization includes:

__ Discharge Summary __ Progress / Physicians Notes __ X-Ray Report

__ History and Physical __ Nurses Notes __ EKG / EMG / EEG Report

__ Emergency Report __ Laboratory Report __ Operative Report

__ Pathology Report __ Consult Report __ Entire Record
Other: _____

Records for the period (MM/DD/YY) from _____ to _____

MY HIGHLY CONFIDENTIAL INFORMATION

By checking any of the boxes next to a category of highly confidential information listed below. I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization.

- Information about mental health or mental retardation services
- Psychotherapy Notes created by mental health professional
- Information about HIV/ AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- Information about sexually transmitted diseases
- Information about alcohol or drug abuse treatment program services
- Information about sexual assault
- Information about child abuse and neglect

One Health

I understand that this authorization will remain in effect until the term of this authorization expires or I provide a written notice of revocation to One Health at the address listed below. The revocation will be in effect immediately upon One health's receipt of my written notice, except that the revocation will not have a ny effect on any action taken by One Health in reliance on the authorization before it received my written notice of revocation.

! understand that there may be a charge for producing record copies according to state regulations.

I may contact One Health Privacy Office at:

Corporate Compliance & Privacy Office One Health
2020 Calamos Ct. I 2nd Floor I Naperville, Illinois

I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of me health information.

By signature, I hereby knowingly and voluntarily authorize One Health to use or disclose my health information in the manner described above.

Signature _____ Date _____