Authorization for Release of Protected Health Information (PHI)

Oak St. Health

Patient Name (Records to be released):_____

Street:_____

City:_____ State:_____ ZIP Code:_____

Telephone:_____ Date of Birth:_____

1. **Records** to be disclosed:
   ☐ Complete medical history ☐ Lab reports ☐ Immunization history ☐ Itemized billing

2. **Sensitive Records** to be disclosed (must select at least one option):
   ☐ Sexually transmitted diseases/infections lab results ☐ Behavioral health
   ☐ Alcohol or substance abuse ☐ Request excludes sensitive records

3. **Dates of Service** to be disclosed: ☐ ALL Dates of Service
   ☐ Specific Dates of Service:_____

4. My Records may be disclosed **to the following person or company:**

   ☐ Oak Street Health – Medical Records
   2655 Warrenville Road, 3rd Floor
   Downers Grove, IL 60515
   Fax: 773-437-6797

   ☐ _____
   Person or Company Name

   _____
   Mailing Address/Email Address

5. I authorize the disclosure of my Records **for the purpose of:**
   ☐ At the request of Patient or Patient's Personal Representative (no specific purpose)

   ☐ Specific Purpose:_____

6. This Authorization remains in effect until I revoke it unless I enter a different expiration date here:_____ / _____ / _____

7. **By signing below, I understand and agree that:**
   - My Records may include sensitive information related to the treatment of mental health conditions, alcohol or substance abuse, sexually transmitted diseases like HIV/AIDS or other communicable and non-communicable diseases, and genetic marker information.
   - I may revoke this authorization at any time by writing to Oak Street Health at the address, email or fax number at the bottom of this form, except to the extent that Oak Street Health has already relied on this authorization.
   - I understand that signing this authorization is voluntary and that this authorization will not affect my ability to obtain treatment, payment for treatment or enrollment or eligibility for benefits from Oak Street Health. A photocopy or facsimile of this signed Authorization is as valid as the original and will be accepted.
   - Whoever gets my PHI may share it with others. That means federal or state privacy laws may no longer protect my PHI.
   - I understand that I have the right to receive a copy of this Authorization.

_____ _____
Signature of Patient/Personal Representative* Date

*If signed by someone other than the patient, please print your full name, explain your authority to act on behalf of this patient, and provide us paperwork evidencing this authority (e.g., Power of Attorney or Guardianship form):

_____