OAK STREET HEALTH

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PLEASE PRINT CLEARLY

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf.

TO RELEASE INFORMATION FROM MY MEDICAL RECORDS AND CLAIMS DATA, AND SEND TO THE FOLLOWING:

Oak Street Health – Center
Address
City, State Zip
phone: Phone
fax: Fax

Oak Street Health – Medical Records
1520 Kensington Rd Suite 310
Oak Brook, IL 60523
phone: Med Records Phone
fax: 773-437-6797

Further, I authorize use of my medical records from the Medicare Blue Button program, which includes any and all records including claims data, Preventive Services, Past Medical Claims Past Prescription Drug Claims Patient-sourced information, Drugs, Emergency Contacts, Family Medical History, Pharmacies, Plans, Providers, Self-Reported Health Information. This form documents my provision of these medical records and authorization of use to OSH.

I authorize you to release my medical record to the Physicians named above subject to the following restrictions, if any:

☑ **NO LIMITATIONS** - Including HIV/Substance Abuse/Mental or Behavioral Health

☐ **LIMITATIONS**: Check all related information that you DON'T want released:
☐ HIV/AIDS ☐ BEHAVIORAL HEALTH (SUBSTANCE ABUSE OR MENTAL HEALTH)

SPECIFIC RECORDS: ☐ LABS ☐ OPERATIVE REPORT ☐ OTHER

Purpose or need for information:

☑ FURTHER MEDICAL CARE ☐ PERSONAL USE ☐ DISABILITY ☐ OTHER (please specify) _____

I understand that I may revoke this authorization in writing submitted at any time to Oak Street Health, except to the extent that action has been taken in reliance on this authorization, this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate at the end of the patient relationship with Oak Street Health.

I understand that Oak Street will not condition treatment or eligibility for care on my providing this authorization except if such care is research related or provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 Code of Federal Regulations, Part 164], and the Privacy Act of 1974 [5 United States Code (U.S.C.) 552a].

SIGNATURE OF PATIENT: _____ DATE: _____