OAK STREET HEALTH

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

FROM: Oak Street Health
Street Address: ____________________
City, State and Zip Code: ____________________
Patient Name: ____________________
Date of Birth: ____________________

Disclose Information TO: RECORDS DEPOSITION SERVICE
P.O. BOX 5054
City SOUTHFIELD **State** MI **Zip** 48086-5054
Phone: (248) 357-3330 **Fax:** (248) 357-3337
E-Mail: INFO@RECDEP.COM

Purpose of disclosure: Date or range of dates of requested information:
LEGAL DISCOVERY BEFORE TRIAL

I request the release of the following information (INITIAL ALL THAT APPLY):

____COMPLETE HEALTH RECORD ___ X-rays ____Lab Tests/Reports
____Discharge Summary ___ Radiology ____Case Management Notes/Reports
____History and Physical Exams ___ EKG/EEG ____Other (specify): ____________
____Physician/Consultation ___ Reports Progress Notes

I authorize the disclosure of my information to the individual(s) indicated on this form. I expressly request that Oak Street Health disclose full and complete protected medical information including the following:

- · All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, r ports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.
- · All physical, occupational and rehab requests, consultations and progress notes.
- · All disability, Medicaid or Medicare records including claim forms and record of denial of benefits. All employment, personnel or wage records.
- · All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myelogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.

- · All pharmacy/prescription records including NDC numbers and drug information handouts/monographs. **All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period ___________ to ____________.**

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

Initials ______
Date ________

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.
Oak Street Health is authorized to release the above information to the following individuals on their request and reserves the right to ask for a specific data set but may not deny a request for the entire records file:

I understand the following:
a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
Any facsimile copy or photocopy of the authorization shall authorize you to release the records requested herein.

Signature of Patient or Legally Authorized Representative:

____

Date:

____ **If signed by Legally Authorized Representative, Name and Relationship of Legally Authorized Representative to Patient**____