AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize OSF Healthcare System to conduct an investigation into my background and activities to ascertain and determine the question of my qualifications and eligibility for the medical (professional) staff membership and/or the granting and continued exercise of clinical privileges at any OSF facility in which I have requested membership and/or clinical privileges and/or participation in the OSF Direct Access Network.

I hereby authorize all educational institutions, medical/dental societies, associations, current and former professional liability insurance companies, managed care organizations, examining board of the state(s) in which I have been licensed, members of such examining boards, all professionals with whom I have worked, hospitals, surgery centers and clinics in which I have trained and worked, and the medical staff members of such hospitals, surgery centers and clinics to:

(a) furnish to OSF Healthcare System all information in their possession which might have any bearing upon my professional ability, qualifications, training, background, ethics, physical and mental health, emotional stability and any other matter relevant to my eligibility for medical (professional) staff membership and/or to be granted and to exercise clinical privileges at any OSF facility in which I have requested membership and/or clinical privileges and/or participation in the OSF Direct Access Network including but not limited to immunization records;
(b) notify OSF Healthcare System in the event of a suspension, change, reduction, termination or revocation of any license, privilege or membership granted to me by such organization and to furnish to OSF Healthcare System any and all information in their possession concerning such change.

I hereby release and hold harmless:

(a) all entities and individuals enumerated above from any and all liabilities they may have to me for the release of the information, records and other documents enumerated above, including any opinions, favorable or unfavorable, expressed by any such individual or organization, and any liabilities that might result therefrom; and
(b) OSF Healthcare System and all its entities, its board members, officers, medical (professional) staff members, agents and employees from any and all liabilities they may have to me for their acts performed in good faith and without malice in connection with their evaluation of me and my credentials.

I acknowledge that I have received and read the OSF Healthcare System Release of Information form, I authorize release of information as permitted by said form, and I release OSF Healthcare System and all its entities, its board members, officers, medical (professional) staff members, agents and employees from any and all liabilities they may have to me for the release of information pursuant to the policy.

A copy of the signed original of this Release of Information shall have the same force and effect as the signed original. This Release of Information shall be valid for a period of two years for OSF facilities and three years for the OSF Direct Access Network following its execution.

_____
Print or Type Applicant's Name

_____ _____
Applicant's Legal Signature Date