

**OSF Direct Access Network  
OSF Saint Francis, Inc.  
Release of Information**

I, \_\_\_\_\_ hereby authorize OSF Saint Francis, Inc. ("OSFSFI") to conduct an investigation into my background and activities to ascertain and determine the question of my qualifications and eligibility for the participation in the OSF Direct Access Network ("Network").

I hereby authorize all schools, medical/dental societies, associations, current and former professional liabilities insurance companies, 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 of such hospitals, surgery centers and clinics to:

- a) furnish to OSFSFI 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 in the Network;
- b) notify OSFSFI 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 OSFSFI any and all information in their possession concerning such change.

I hereby release:

- a) all schools, medical/dental societies, associations, insurance companies, boards, hospitals, surgery centers, clinics, 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, expresses by any such individual or organization, and any liabilities that might result there from.
- b) OSFSFI, and their representatives 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 am part of the provider group \_\_\_\_\_. I agree to abide by the terms and provisions of the group provider contract, including provisions on product participation with OSFSFI.

I acknowledge that I have received and read the OSFSFI Confidentiality of Credentialing Information Policy, I authorize release of information as permitted by that policy, and I release OSFSFI and their representatives 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 Release of Information shall have the same force and effect as the signed original.

\_\_\_\_\_  
PRINTED OR TYPED APPLICANT'S NAME

\_\_\_\_\_  
APPLICANT'S SIGNATURE

\_\_\_\_\_  
DATE