CONSENT, RELEASE AND ACKNOWLEDGEMENT

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications ('peer review information') by and between Health Care Organizations (e.g. hospital medical staffs, medical provider groups, independent practice associations (IPAs), health plans, health maintenance organizations (HMOs), preferred provider organization (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and businesses and individuals acting as their agents-collectively Health Care Organization) for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect peer review records from further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and /or communications in connection with evaluating the qualifications for healthcare providers. I hereby release all persons and entities engaged in quality assessment, peer review, and credentialing on behalf of all persons and entities providing peer review information to such Health Care Organization (HCO) representatives from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in HCO, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded fair procedures with respect to my participation in HCO's as may be required by state and federal law and regulation. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of any professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications. I agree to update the application should there be any change in the information provided.

I also agree to notify HCO's in writing, within seven(7) days of receiving any written or oral notice of any adverse action, including, without limitation, any filed and served malpractice suit or arbitration action; any adverse action by any federal, state, or local medical and/or professional board taken or pending, including but not limited to, any accusation filed, temporary restraining order or interim suspension or revocation of licensure; any adverse action taken by any HCO, or a report with the National Practitioner Data Bank; any revocation of DEA license; a conviction of any felony or a misdemeanor of moral turpitude; any action against any certification under the Medicare or Medicaid programs; or any cancellation, non-renewal or material reduction in medical liability insurance policy coverage.

I acknowledge that before agreeing to this consent, I have reviewed my Authorized HCOs' and any future authorized HCOs' privacy policy and practices, including how the HCO uses confidential health information to carry out treatment, payment, and health care operations, such as credentialing and peer review. By applying for appointment/reappointment to the medical staff of my Authorized HCOs and any future authorized HCOs, I consent to the HCO's use and disclosure of my health information to carry out treatment, payment, and health care operations, in accordance with the terms of their notices. I understand that the terms of my Authorized HCOs and any future authorized HCO's privacy notices are subject to change, and that I can get a copy of the revised notice directly from the HCO's. I understand that I have the right to request that my Authorized HCOs and any future authorized HCO's restrict how they use my personal health information (PHI) to carry out treatment, payment, and health care operations. I also understand that my Authorized HCO's and any future authorized HCO's are not required to agree to the restrictions I request and that if my Authorized HCO's and any future authorized HCO's agree to a restriction, the restriction will be binding on my Authorized HCO's and any future authorized HCO's. I also understand that I may revoke this consent at anytime, except to the extent that action has already been taken by my Authorized HCO's and any future authorized HCO's in reliance on my consent. A "Digital Signature" is defined as an electronic identifier and signing authority, created by a user, and intended by the party using it to have the same force and effect as the use of an original signature. To do this, the digital signature needs to embody all of the following attributes: 1) It is unique to the person using it 2) It is verifiable 3) It is under the sole control of the person using it 4) It is linked to data in such a manner that if the data is changed, the digital signature is invalidated.

I hereby affirm that the information submitted in this application and any addenda thereto is true to the best of my knowledge and belief and furnished in good faith. I understand that omissions or misrepresentations may result in denial of my application or termination of my privileges, employment, or provider participation agreement.

Provider Name: _____

Provider Signature: _____ Date: _____