

# AUTHORIZATION AND RELEASE OF APPLICANT

PLEASE READ CAREFULLY BEFORE SIGNING

I understand and acknowledge that, as an applicant for medical/professional staff at the hospital or ambulatory care center, state and county medical society membership, or affiliation with a health care network or plan (hereafter referred to as "Organizations") indicated in this Application, it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/or experience, current competence, judgment, health status, character, ethics and any other criteria adopted by Organizations for medical/professional staff membership or medical and/or surgical privileges or affiliation.

I further acknowledge that I am responsible for knowing the contents of the bylaws, rules and regulations of the Organizations and their medical/professional staffs and agree to be bound by them if granted membership and/or privileges or affiliation.

I further understand and acknowledge that the Tennessee Physicians' Quality Verification Organization, LLC ("TPQVO") acting as a contractor for the Organizations will investigate the information in this Application. By submitting this Application, I agree and consent to such investigation activities of TPQVO and Organizations as follows:

**Authorization of Investigation and Release of Information Concerning Application for Appointment.** I authorize all individuals, institutions and entities, including but not limited to administrators and members of the medical/professional staffs of other facilities, organizations or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who have knowledge concerning information requested in this Application to consult with and release relevant information to TPQVO and Organizations, their medical/professional staffs, credentialing committees and agents.

**Release from Liability.** I hereby release from liability Organizations, TPQVO and their respective agents, and all other individuals, institutions and entities providing information in accordance with the authorizations contained herein for their acts performed in connection with the investigation of this Application for Appointment. This release shall be cumulative and in addition to any other applicable immunities provided by law for medical care review activities.

**Use of Information.** I acknowledge that part of the information to be provided by me is for identification purposes only and will not be used to form the basis of decisions regarding medical/professional staff membership or credentialed status.

I understand and agree that the authorizations I have provided are irrevocable so long as I am an applicant for or have medical/professional staff privileges at or am affiliated with any Organizations participating in TPQVO's central verification service.

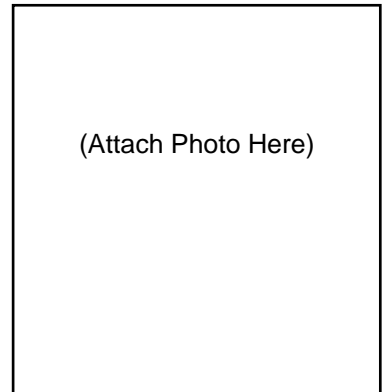
I acknowledge that the investigation of information in this Application by the Organizations, TPQVO and their agents is done to achieve, maintain and improve quality patient care.

I agree to provide continuous care for each of my patients and recognize my responsibilities therein.

I consent to an inspection of my records and agree to an interview if requested.

All information provided by me in the Application is true and complete to the best of my knowledge and belief. I understand and agree that any material misstatement in or omission from the Application may constitute grounds for denial of appointment or for summary dismissal from the medical/professional staff of the Organization(s). I understand and acknowledge that the Organizations shall be solely responsible for all decisions concerning medical/professional staff membership and the granting of medical and/or surgical privileges or credentialed status. Medical/professional staff membership are determined independently by each Organization. I further understand and acknowledge that TPQVO has no responsibility or liability with respect to medical/professional staff membership or credentialing decisions by Organizations.

I further acknowledge that I have read and understand the foregoing Authorization and Release.



Name (Please print) \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

A photocopy of this Authorization and Release shall be as effective as the original.