AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize ________________ Group or its retained representatives to consult with any and all persons who can furnish information, records or documents, which may have a bearing on my professional competence, character, and ethical qualifications. This document also authorizes all individuals, companies or government entities to release to ________________ Group or its representatives any and all information, records, or documents necessary to complete its investigation. Said information may concern but is not necessarily limited to my current or past employment and education. ___________________ Group shall also have the right to information concerning any criminal arrests, convictions or investigations.

I also authorize ________________ Group or its representatives to consult with administrators and members of medical staffs of other hospitals/clinics or institutions with which I have been associated and with others, including personal references and past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications.

I hereby release from liability any and all individuals and organizations that provide information in good faith and without malice to ____________________ Group or its representatives, and I hereby consent to the release of such information.

____
John Doe, M.D. Date

____
Date of Birth

____
Social Security Number

SAMPLE

AUTHORIZATION FOR RELEASE OF INFORMATION

- I understand that all references to __________ hospital include any ___________ hospital.-affiliated entity or medical/professional staff, and their authorized representative(s).

- I hereby authorize __________ hospital to consult with any and all persons who can furnish information, records, or documents which may have a bearing on my professional competence, character, and ethical qualification.

- This document also authorizes all individuals, companies, or government entities to release to __________ hospital any and all information, records, or documents necessary to complete its investigation. Said information may concern but is not necessarily limited to my current or past employment, education, credit ratings, professional competence, ethics, character, and other qualifications for employment. __________ hospital shall also have the right to information concerning any criminal arrest, conviction, or investigation.

- I also authorize __________ hospital to consult with administrators and members of medical staffs of other hospitals, clinics, or institutions with which I have been associated and with others, including personal references and past and present malpractice carriers, who may have information bearing on my professional competence, character, and ethical qualifications.

- I hereby release from liability all individuals and organizations that provide information in good faith and without malice to __________ hospital and I hereby consent to the release of such information. I release __________ hospital from liability, to the fullest extent allowed by the law for its acts performed in connection with evaluating my credentials and qualifications.

- I further authorize __________ hospital to release information in accordance with __________ hospital's standard policies pertaining to sharing and / or release of confidential information.

____
SIGNATURE

____
DATE

SAMPLE

AUTHORIZATION FOR RELEASE OF INFORMATION

<Hospital or Clinic Name>

By signing this Authorization to Release Information, I, the undersigned, hereby consent to the inspection by <CLINIC> and its designated representatives of all records and documents that may be material to an evaluation of my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, financial condition or any other matter that may be considered material to my qualification for employment/staff affiliation. I understand that this may include the inspection and/or verification of educational and training records, professional organizational and/or association records, work experience, current and past licensure records, certification records, professional liability insurance records, and contact with personal and/or professional references, National Practitioner Data Bank query (requires DOB and social security number) and any other records or third parties that may have direct bearing upon my application.

Additionally, I, the undersigned hereby release from liability all representatives and agents of aforementioned organization for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from liability any and all individuals and organizations who provide information to this facility's representative(s), in good faith and without malice and I hereby consent to the release of such information.

A copy of this Authorization to Release Information shall be as binding as the original.

________________________________ ________________________

Signature Date

________________________________ ________________________

Please print name Social Security Number

____

Date

SAMPLE

Authorization for Release of Information

I, ____, authorize ABC Medical Center and/or its authorized representatives to consult corporations, companies, credit agencies, educational institutions, persons, law enforcement agencies, military services, former employers, and any other third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, mental and/or emotional stability, physical condition, ethics, behavior, financial condition or any other matter, as well as to inspect or obtain any and all communications, reports (including but not limited to credit reports), records, statements, documents, recommendations, or disclosures of said third parties that may be material to such questions.

I also authorize said third parties to release said information to ABC Medical Center and/or its authorized representatives upon request. I hereby release from any liability, any and all individuals and institutions or organizations who in good faith and without malice concerning any professional competence, ethics, character, education, training, licensing, and other qualifications, provide information to ABC Medical Center and/or its agents.

I understand this notice will also apply to any future update reports that may be requested. A copy of this Authorization for Release of Information shall be as binding as the original.

________________________________	________________________________
Date	Print Full Name
________________________________	________________________________
Social Security Number	Signature
________________________________	________________________________
Date of Birth	Driver's License Number & State
________________________________	________________________________
Medical License Number & State	Current Home Address:
	________________________________

SAMPLE

XYZ HOSPITAL
AUTHORIZATION FOR RELEASE OF INFORMATION
AND
RELEASE OF LIABILITY

I authorize hospital representatives to consult with others who have been associated with me and/or who may have information bearing on my competence and qualifications.

I consent to hospital representatives' inspection of all reports and documents that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges I request, of my physical and mental health status and of my professional ethical qualifications.

I release from any liability all hospital representatives for their acts performed in good faith and without malice in connection with evaluation of me and my credentials.

I release from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to hospital representatives in good faith and without malice concerning my competence, professional ethics, character, physical and mental health, emotional stability and other qualifications for staff appointment and clinical privileges.

I authorize and consent to hospital representatives providing other hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters that the hospital may have concerning me, and release hospital representatives from liability for so doing, provided that such furnishing of information is done in good faith and without malice.

Applicant further agrees that a photocopy of this authorization for Release of Information and Release of Liability shall be valid as the original hereof.

____
Date

____
Signature of Applicant

____
Typed or Printed Name of Applicant

SAMPLE

DISCLOSURE / CONSENT / AUTHORIZATION FOR RELEASE OF INFORMATION

This form will not be accepted if altered, modified, illegible or incomplete

By signing this form, I acknowledge I am aware that an investigative consumer report / background check will be conducted by the organization known as **PUT INCLIENTSNAME** in connection with my application for employment and/or affiliation. I further acknowledge and consent to the inspection by said organization or its representative, **AccuCheck Inc.**, a Consumer Reporting Agency, (800-874-9099) of all records and documents that may be material to an evaluation of my professional qualifications, credentials, clinical competence, character, general reputation, ethics, behavior, or any other matter that may be considered material to my qualification or re-qualification for affiliation, appointment or employment (including contract for services). I understand that this investigative consumer report may include the inspection and/or verification of any information provided to the above named sources in the form of an application, CV or resume, or information gained from third party informants including the following sources: educational and training records, professional organization or association records, civil and criminal court records, public local, county, state or federal court records, licensing boards, certifying boards and agencies, regulatory agencies, NPDB as designated agent for aforementioned organization, insurance claims records, driving records, contact with references and any other records or third parties that may have information bearing upon my application. Additionally, I hereby consent to the release of my military personnel records and I authorize the National Personnel Records Center, or other custodian of my military records to release the information and/or copies of military service record documentation.
Contact with, and information provided from the above sources delineates the nature and scope of the investigative consumer report prepared by AccuCheck Inc.
I acknowledge that I may receive a written summary of my rights pursuant to the Fair Credit Reporting Act (FCRA) as regulated by the Consumer Financial Protection Bureau (CFPB).
. I provide my consent and authorize any of the aforementioned sources to furnish information and/or verification of information as requested and acknowledge that this Disclosure & Authorization is in effect throughout the application process and any future employment and/or affiliation with the organization named above. I acknowledge that a copy of this Disclosure & Authorization for Release of Information shall be as binding as the original.

______________________ ______________________ ______________________

Print LAST Name **Print FIRST Name** **Print MIDDLE Name**

Required: Manual Signature ______________________________ Date:__________

****Consent to contact Current Employer****

___ **YES AccuCheck may contact my current employer** ___ **NO AccuCheck MAY NOT contact my current employer**

Print current employer name ______________________________ * N/A:________

I acknowledge that the identifying information requested below is for purposes of receipt, review and proper identification of any/all source information as outlined above. Personal identifying information (information below this sentence) will not be provided to any sources (ie: peer references, etc.) that do not require same for verification purposes.

______________________ ______________________

Print Name as commonly used (if different than above) Social Security # / Social Insurance # (if none specify "none" above)

______________ ______________ ______________

Date of Birth (month / day / year) Gender (specify Female or Male) DEA Registration #

______________ ______________ 0-______________

Drivers License # (exactly as it appears on Drivers License) State issuing Drivers License ECFMG Certification # (if applicable)

____

List above former names; First and/or Last names and time period name/s used (maiden names, former married, aliases, etc.)

Licensure:____
List Medical Licensure Above -Include Active, Inactive, Expired, Cancelled, etc. – list issuing state/country (WI, AK, MO, CN etc)

Practice Location/s (Provide a minimum 7 year history; list locations of practice; use additional form if needed)

Hospital, Practice, Office Name	location (city/state)	(to) **dates**
Hospital, Practice, Office Name	location (city/state)	(to) **dates**
Hospital, Practice, Office Name	location (city/state)	(to) **dates**
Hospital, Practice, Office Name	location (city/state)	(to) **dates**

CA, MN, OK residents only: Initial & Date when requesting a mailed or emailed copy of consumer report ______________
Initials / Date

Mailing Address or Secure Email Address:____________________City:______________ State:__________Zip:________

SAMPLE