CONSENT, ATTESTATION & AUTHORIZATION FOR RELEASE OF INFORMATION

A copy will serve as original

I hereby authorize any third party, (including but not limited to individuals, medical groups, hospitals, insurance companies, health plans, licensing agencies, medical societies, agencies, corporations, companies, employers, etc.) to release information concerning my qualifications, credentials, clinical competence, quality assurance data, character, physical or mental health condition, behavior, ethics, claims history, disciplinary actions, or any other matter reasonably having bearing on qualifications. I release said third parties or entities from liability and hold harmless any entity or third party for their acts performed in connection with the release of such information and acknowledge that the information obtained is not a violation of my privacy.

I hereby authorize Lakeview Surgery Center (LSC), its medical staff and/or representatives to collect and review all records and documents, including records from previous education, training and licensure; board certification status; and responses to queries to the National Practitioner Data Bank, that may be material to an evaluation of my professional qualifications and competence. I also authorize consults with administrators, and members of medical staff of other institutions with which I have been associated, professional references and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection of all records and documents, including medical records, at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for staff membership. I hereby release Lakeview Surgery Center and its employees, representatives, and affiliates from liability when gathering, obtaining and exchanging documents, records, and other information pertaining to my application.

It is my understanding that LSC shall treat the information provided herein or on any attachments hereto, and on any documents submitted or collected in support of this application as confidential and shall only disclose such information to third parties as required for purposes approved by me, or as required under state or federal law or regulation. I hereby further authorize and consent to the release of information by LSC, or its medical staff, to other hospitals, medical associations and other interested persons on request regarding any information LSC its representatives and the medical staff may have concerning me as long as such release of information is done and I hereby release from liability LSC and its staff for so doing.

I fully understand that any misstatements in or omissions from this application may constitute cause for denial of appointment or cause for summary dismissal from the medical staff. All information submitted by me in this application is true and complete to my best knowledge and belief. I hereby signify my willingness to appear for the interviews in regard to my application,

I understand and agree that I, as an applicant for medical staff membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications. I agree to be bound by the bylaws of the medical staff, rules and regulations, policies and procedures as put forth by the governing body.

I also understand that certain fields of data on this application contain time sensitive information and must be updated from time to time, as required by specific credentialing criteria; in that regard, I authorize LSC to collect from me and other sources this information on an as needed basis.

I have read and understand the attestations, acknowledgements and releases outlined in this form and agree to them. I acknowledge that acceptance of this application does not constitute a contractual agreement for employment, membership, or granting of privileges. I agree to notify Lakeview Surgery Center within 10 working days of any material change to the information reported on the application, including but not limited to, changes in status at other organizations, restrictions to any license, commencement of a formal investigation, or changes in physical or mental health.

_____ _____

Printed Full Name & Signature Date