Hope Healthcare Services

Authorization for Release of Information

In order for Hope Healthcare Services to assess and verify professional qualifications, competency, and suitability for appointment as an Allied Health or Medical Staff volunteer, I hereby authorize disclosure of the following documents to Hope Healthcare Services (HHS):

1. Verification of past and present hospital / educational affiliations
2. Board certification
3. Licensure
4. DEA and State controlled substance registration.

I authorize disclosure of the following, only when necessary, to verify my professional background and history for appointment at Hope Healthcare Services:

1. National Provider Identifier
2. Date of Birth
3. Other identifiers as requested by the verifying organization
4. Last 4 digits of social security number

I authorize the disclosure of my photograph for purposes of identification to professional references, affiliates and members of HHS.

I release from liability all representatives of Hope Healthcare Services and its medical staff for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications.

I hereby release from liability any and all individuals and organizations that provide information to HHS or to members of its staff in good faith and without malice concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

_____ _____

Signature Date

_____

Printed Name .