

Authorization for Release of Information and Applicant's Agreement for Appointment or Reappointment to the Allied Health Professional Staff

The term, "Allied Health Professional" as used in this document, includes any individual health care provider, other than a licensed physician, dentist or podiatrist, who holds a license, certificate or other credentials as required by applicable State or other law and who is granted and may exercise delineated clinical privileges or work within an assigned scope of practice within the area of his/her professional competence. AHPs shall include, but are not limited to, physician assistants, advance practice nurses, clinical psychologists and qualified therapists (e.g., occupational, physical, respiratory).

1. Misstatements and Omissions

I fully understand that any misstatements in or omissions from my application for appointment or reappointment may constitute cause for denial of appointment or reappointment or removal from the Allied Health Professional Staff of the hospital in healthcare entity/facility.

2. Appointment Not a Right

I acknowledge that:

- (a) allied health professional staff appointment and clinical privileges at this hospital are not a right of every healthcare professional who submits an application for appointment or reappointment, and
- (b) my application for appointment or reappointment and my request for clinical privileges will be evaluated in accordance with prescribed procedures defined in the hospital/facility and medical staff bylaws, rules and regulations.

3. Conditions to Appointment/Reappointment

I acknowledge that the agreement, authorizations, and releases set forth in this document are express conditions to my application for acceptance of, and appointment or reappointment, to the Allied Health Professional Staff and the continuation of such appointment or reappointment and to my exercise of clinical privileges at the hospital.

4. Burden of Producing Information

I hereby acknowledge that I, as an applicant for Allied Health Professional appointment or reappointment, have the sole burden of producing adequate information for a proper evaluation of my professional, ethical, health and other qualifications for Medical Staff membership and clinical privileges and for resolving any doubts about such qualifications, and that my application will not be processed if I fail to provide or fail to obtain any information required or requested. I agree to appear for interviews regarding my application.

5. Bylaws, Rules and Regulations

I certify that I have read and am familiar with, and agree to abide and be bound by, the bylaws, rules and regulations, and policies of the Medical Staff, as now written and as may be amended from time to time.

6. Agreement

- (a) I agree to provide continuous care for all my patients admitted to the hospital, either by personally caring for the patients or arranging for coverage by another qualified member of the Medical Staff.
- (b) If appointed or granted clinical privileges, I agree to:
 - (i) refrain from delegating responsibility for diagnoses or care of hospitalized patients to any practitioner who is not qualified to undertake this responsibility or who is not adequately supervised, and
 - (ii) accept committee assignments and such other duties and responsibilities as shall assigned to me by the hospital board and/or the Medical Staff.
- (c) I agree to notify the Chief of Staff in writing (note to be sent in care of the Medical Staff office) of any of the following circumstances within fifteen (15) days of my receipt of written or verbal notice of same:
 - (i) Reduction, suspension, limitation, revocation, voluntary or involuntary relinquishment or any diminishment of my staff status or privileges at any hospital or health care facility, excluding suspension of clinical privileges for less than thirty (30) days based upon failure to complete medical charts;
 - (ii) Reduction, suspension, limitation, revocation, cancellation or any diminishment of my professional license, my Drug Enforcement Agency certificate, professional liability insurance, or any other certificate or permit to prescribe or administer controlled substances;
 - (iii) commencement of a formal investigation or the filing of charges by any law enforcement agency or health regulation agency, excluding (a) traffic offenses that do not involve allegations of driving while intoxicated or under the influence and (b) inquiry letters received from the CMS QIO contractor or other peer review organizations; and
 - (iv) commencement of a formal investigation by any hospital or healthcare entity
- (d) I agree to notify the Chief of Staff in writing (notice to be sent in care of the Medical Staff Office) of the filing of a civil suit against me alleging professional liability within sixty (60) days of my receipt of written or verbal notice of same.

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- (e) I agree to report any changes in my physical or mental health that could potentially affect my ability to safely and appropriately exercise all or any of the privileges requested within fifteen (15) days of any such change. I also agree to submit to an examination acceptable to the Medical Staff Executive Committee, the Board of Directors, Officers, Employees, and Agents or any committee responsible to evaluating my credentials should such examination be considered necessary in their sole discretion.
- (f) Failure to notify the Chief of Staff of any of the situations described in this Section 6 within the prescribed time period may be grounds for disciplinary action, up to and including termination of my Medical Staff privileges.
- (g) If I am appointed to the Allied Health Professional Staff, I agree to maintain all information that is confidential or privileged under law in strict confidence and to abide by all Medical Staff bylaw provisions, rules, regulations, and policies concerning privileged or confidential information.

7. Authorization for Release of Information/Notifications/Consultations/Investigations

I request and authorize this hospital, other hospitals and institutions with which I have been or may have been associated, their medical staffs, the professional licensing board of any state in which I hold or may have held a license to practice my profession, professional societies, other third parties and organizations, and their representatives to release information, records, and documents, including medical records and quality assurance data, concerning my professional qualifications and competence, ethics, character, physical and mental health, and other qualifications for Allied Health Professional Staff appointment, reappointment and/or clinical privileges requested at this or any other health care facility. I further authorize this hospital, its representatives and medical staff to notify any other hospital or institution at which I have clinical privileges of any action taken by this hospital that may be reportable to the Texas Medical Board under the Texas Medical Practice Act or the Health Care Quality Improvement Act of 1986, as they may be amended periodically. I further request and authorize the hospital, its representatives, and members of the hospital's Medical Staff and their representatives to consult with representatives of other hospitals and institutions and members of medical staffs of other hospitals and institutions and members of medical staffs of other hospitals and institutions with which I am or may have been associated, and with all others who may have information related to my professional qualifications and competence, my character, ethical qualifications, physical or mental health status and ability to work cooperatively with others. I also authorize members of the Medical Staff and their representatives to conduct further investigation(s) regarding my qualifications for Medical Staff membership and clinical privileges they deem necessary.

8. Immunity and Release

By applying for appointment or reappointment and clinical privileges, regardless of whether or not I am granted appointment, reappointment or privileges, I extend absolute immunity to, and release and hold harmless from any and all liability; (i) the hospital, their representatives, its Medical Staff, its Board of Directors, Officers, Employees, and Agents; (ii) other hospitals, health care facilities and institutions providing information, their representatives to, from, or by any third party, including otherwise privileged or confidential information, relating but not limited to the following:

- (a) applications for appointment or clinical privileges, including temporary privileges;
- (b) periodic reappraisals undertaken for reappointment or for increase or decrease in clinical privileges;
- (c) proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary action or sanction;
- (d) summary suspensions;
- (e) hearings and appellate reviews;
- (f) medical care (quality assurance) evaluations;
- (g) utilization reviews;
- (h) any other hospital, medical staff, department, service or committee activities;
- (i) matters or inquiries concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior and
- (j) any other matter that might directly or indirectly affect my ability to safely and appropriately exercise all or any of the privileges requested.

9. Certification

By my signature below, I certify that all information submitted in my application and in all supporting documents is true, complete and correct. I agree to supplement the information in my application and supporting documents should any statement, although true when made, become untrue due to a change in circumstances or discovery of new information.

A photocopy or facsimile of this authorization shall be as valid as the original and shall be valid from the date signed.

Printed/Typed Name of Applicant _____

Signature of Applicant _____ Date Signed _____