COASTAL HEALTHCARE RESOURCES

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# STATEMENT OF ANESTHESIA PROFESSIONAL

(Authorization for Release of Information)

I, _____, HEREBY CONFIRM THAT ALL INFORMATION GIVEN IN OR ATTACHED TO THIS PROVIDER DATA SHEET IS ACCURATE AND VOLUNTARILY SUPPLIED BY MYSELF.

I hereby authorize Coastal Healthcare Resources, its affiliates and successors, to obtain any information that may be relevant to an evaluation of my professional qualifications for privileging, including information pertaining to disciplinary actions, criminal background, drug screen results, education, work history, or other confidential or privileged information, and other credential documents.

I authorize Coastal Healthcare Resources to disclose to current, prior, or potential contractors making a reasonable inquiry, information relating to my qualifications, ability, and character.

Only to the extent requested and required by the practices, facilities, groups and hospitals staffed or managed by Coastal Healthcare Resources where I will be providing clinical services, I agree to provide and authorize the release of the same by Coastal Healthcare Resources to Coastal Healthcare Resources clients, the following: a) vaccination records; b) reasonable documentation evidencing that I am in good health and free of communicable diseases; c) the result of and/or a copy of my criminal background check, if any and d) the result of and/or a copy of my drug screen, if any.

I hereby release Coastal Healthcare Resources, its officers, employees, and agents, and third parties which provide or receive information regarding my credentials, including, but not limited to, all credentialing information sources, individuals or companies who provide references, companies or agencies that perform clinical background checks, and companies that perform drug screens, from any claims, causes of action, damages and expenses, including reasonable attorney's fees arising from or relating to the collection, verification, an dissemination of my credentialing and other information.

I agree to hold Coastal Healthcare Resources harmless from and against any and all claims, causes of action, damages, judgments and expenses, including reasonable attorney's fees, arising from or related to the accuracy of the information provided by me. I understand that this does not contemplate a duty to hold Coastal Healthcare Resources harmless from claims, causes of action and damages which may arise as a result of information provided about me from sources other than me.

This is a continuing authorization and shall be effective from the date of signature below until such time as I have specifically revoked the same in writing.

If any material changes occur affecting my professional status, it is my obligation to notify Coastal Healthcare Resources or the appropriate affiliate or successor as soon as possible. I understated that the decision to subcontract with me or refer me to practice opportunities is solely at the discretion of Coastal Healthcare Resources.

I understand that any information received from references is confidential and may not be released to me without the consent of the reference. I understand, agree and acknowledge that references are not part of my personnel file.

A copy or facsimile of this document shall have the same effect as the original.

This document shall be interpreted according to the laws of the state of South Carolina.

Name: _____ Social Security #: _____

Signature: _____ Date: _____

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