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Indiana University Health

AUTHORIZATION, CONSENT AND RELEASE

The Medical Staff Office at Indiana University Health, Inc. (IUH) is a credentialing verification organization (CVO) providing services to those affiliates of Indiana University Health, Inc. that have entered into a Service Line Agreement with the Medical Staff Office. This Authorization, Consent and Release authorizes the IUH Medical Staff Office to obtain and release information which it receives as the result of its credentialing verification processes to the Medical Staff Offices of those IUH Affiliate(s) ("Affiliate(s)") where I have made application for clinical privileges in accordance with the terms of this document. For purposes of this Authorization, Consent and Release, I understand that the term Affiliate includes any hospital, ambulatory surgery center, clinic, medical office and/or other healthcare entity in which IUH has a direct or indirect ownership interest, the Affiliate's Medical Staff, the IUH CVO and their authorized representatives. My application for Medical Staff membership, Allied Health Professional (AHP) participation status or clinical privileges (my "Application") and this Authorization, Consent and Release are submitted to permit my Affiliate of Indiana University Health, Inc. to determine whether I am qualified to serve as a provider of services at the Affiliate. I acknowledge that Medical Staff membership, AHP participation status and/or clinical privileges at the Affiliate are a privilege, not a right, and that my authorization, consent and release given herein shall not give rise to any obligation of the Affiliate to grant me Medical Staff membership, AHP participation status and/or clinical privileges at the Affiliate, I understand and agree to the terms and conditions set forth below and intend to be legally bound thereby.

- I understand that the Affiliate must evaluate Professional information about me and make appropriate recommendations to the Affiliate's Board of Directors and that such responsibility extends to both the processing of my initial Application and the continual assessment of my competence, qualifications, performance and conduct should I be granted Medical Staff membership, AHP participation status and/or clinical privileges at the Affiliate. For purposes of this Authorization, Consent and Release, I understand that the term "Professional Information" includes, but is not limited to, information about my professional competence, any Disciplinary Action involving me, my qualifications (including, but not limited to, character, mental and emotional stability, physical condition, ethics, performance, conduct, behavior, continuing education and ability to work with others) and any other matter reasonably related to my satisfaction of criteria for granting Medical Staff credentialing, peer review, quality assessment and utilization review; and that the term "Disciplinary Action" includes, but is not limited to, any prior, on-going or contemplated action involving me by a healthcare organization, its administrators or medical or other committee to revoke, deny, suspend, restrict or condition my membership, participation or privileges at or with such organization, to impose a corrective action plan, or to take any other disciplinary action, including formal disciplinary hearings, in an employment context or otherwise; or my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I had knowledge that such formal charges were being or are being contemplated and/or were [or are] in preparation.

- I hereby acknowledge that it will be necessary for the Affiliate to investigate and verify my Professional information and to inquire of persons and institutions, including but not limited to, State and federal licensing, regulatory boards and agencies; prior and current employers; schools, universities and training programs; Affiliates and other health care organizations; IPAs, health plans, HMOs, PPOs and other health delivery systems or entities; professional liability insurance companies; individual practitioners; military services; medical staff credentialing and accreditation agencies; State Medical Boards; applicable State Licensing Boards, the Federation of State Medical Boards; the National Practitioner Data Bank; and any businesses or individuals acting as their agents (collectively, "Third Parties") and other appropriate sources deemed necessary by the Affiliate to obtain information bearing on my Application and the continual assessment of my competence, qualifications, performance and conduct.

- I understand that the Affiliate and its Medical Staff may receive requests for Professional information about me from Third Parties and their authorized representatives.

- I understand that in seeking and exchanging Professional Information about me, candid evaluations may give rise to statements that may be unfavorable or critical of me.

- During the Application process and, if applicable, at any time during which I may retain Medical Staff membership, AHP participation status or clinical privileges at the Affiliate, I hereby agree to immediately and fully inform the Affiliate in writing, through the President of the Medical Staff or his/her designee, of any of the following: (i) my receipt of notice of any change in my professional liability insurance coverage; (ii) the filing of any lawsuit against me relating to patient care and/or ethical or professional performance or conduct; (iii) if a physician; any change in my medical staff status or loss or curtailment of any clinical privileges at any other Affiliate or facility at any time; if an AHP practitioner, any change in participation status or loss or curtailment of my clinical privileges at any other Affiliate or facility at any time; (iv) any suspension, limitation, revocation or dismissal due to quality or utilization concerns about me from any IPA, health plan, HMO, PPO or other managed care organization; (v) my receipt of any written or oral notice of the commencement of (or decision arising out of) any Disciplinary Action or investigation by any professional review board, State or federal regulators, certification

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or licensing board involving me, or any report of the National Practitioner Data Bank about me; (vi) any health or mental condition that could affect my ability to practice or perform the essential functions of my professional duties or would otherwise be a threat to the health or safety of others; or (vii) a conviction against me or a plea bargain for any felony or misdemeanor.

- I hereby acknowledge that I have received the Affiliate's Medical Staff Bylaws and I agree to be bound by them in all matters relating to the consideration of my Application without regard to whether I am granted membership and/or clinical privileges. I also understand that, unless further limited by the terms of the Affiliate's Medical Staff Bylaws or by any agreement entered into by me, I will be afforded the fair hearing procedure set forth in the Affiliate's Medical Staff Bylaws in the event of an adverse decision on my Application and I acknowledge and agree that if any adverse decision is made with respect to me, I will follow and exhaust the administrative remedies afforded by the Medical Staff Bylaws as a prerequisite to any other action regarding my Application.

- I recognize that I have the burden of resolving any reasonable doubts about my qualifications for Medical Staff membership, AHP participation status and/or clinical privileges at the Affiliate.

- I acknowledge that I am familiar with the principles and standards of the Joint Commission (TJC), Healthcare Facility Accreditation Program (HFAP), Accreditation Association for Ambulatory Health Care (AAAHC) and/or the National Committee for Quality Assurance (NCQA) which apply to me.

- If I am granted membership and/or clinical privileges, I pledge to adhere to the ethical standards of my profession and to provide continuous care of all of my patients that meets the standards established by the Affiliate.

- If I am granted membership and/or clinical privileges, I agree to subject my clinical performance to, and faithfully participate in, the quality and utilization management programs of the Affiliate,

I specifically agree and consent to the following:

- To appear, if requested, before authorized representatives of the Affiliate or the Medical Staff for interviews or inquiries regarding my Application or the continual assessment of my competence, qualifications, performance and conduct.

- To assist authorized representatives of the Affiliate or the Medical Staff, in every way possible, in gathering Professional information bearing on my Application or the continual assessment of my competence, qualifications, performance and conduct (including, but not limited to, signing any supplement authorization, consent or release forms that may reasonably be required for the Affiliate to disclose or receive Professional Information in accordance with this Authorization, Consent and Release).

- To appear for interviews and/or undergo mental examination, physical examination, and/or toxicological examination by persons of the Affiliate's choice as may be required at any time by the Affiliate for the purpose of considering my Application or arising out of the continual assessment of my competence, qualifications, performance and conduct. Furthermore, I consent to the disclosure by such persons of their reports to the Affiliate and its Medical Staff/or its authorized representatives.

Authorization to Obtain and Release Information and Waiver:

I hereby authorize the Affiliate and its authorized representatives to consult with any Third Party who may have Professional Information about me.

I hereby request and authorize any Third Party to release Professional Information about me to the Affiliate and its authorized representatives. I acknowledge and agree that any Professional Information obtained or received by the Affiliate shall not be required to be disclosed to me if the Third Party providing such information does so on the condition that it be kept confidential.

I hereby authorize the Affiliate to review, inspect and disclose any and all Professional Information about me to Third Parties and their authorized representatives who, in the sole opinion of the Affiliate, have a legitimate need for such information.

I hereby authorize the Affiliate and its authorized representatives to release Professional Information about me to any party with whom the Affiliate has contractual obligations for the provision of health care services (including, but not limited to, TJC, HFAP, AAAHC & NCQA).

I hereby authorize the Affiliate to release Professional information about me to any peer review, quality assessment, utilization review or risk management committee or department of any other Indiana University Health, Inc. Affiliate or Quality Affiliate for purposes of credentialing; quality assurance; utilization review; peer review; reducing morbidity and mortality; for the improvement of patient care; and/or for any such other purpose reasonably determined by the Affiliate.

I hereby authorize the Affiliate to report to the National Practitioner Data Bank information about me which it believes in good faith is required by law to be reported.

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I hereby waive any claim of privilege or privacy with respect to any information bearing on my Application that is released for purposes of accreditation review; credentialing; re-credentialing; quality assurance; utilization review; retaining Medical Staff membership, AHP participation status, and/or clinical privileges; and/or for any other purpose reasonably determined by the Affiliate.

If a physician, I hereby voluntarily waive the provisions of Section 412(b) of the Health Care Quality Improvement Act of 1986. I understand that this means that I may not later assert that the peer review provisions of the Medical Staff Bylaws of the Affiliate are inconsistent with the peer review notice and hearing requirements under the Act.

Immunity from Liability:
I hereby extend absolute immunity to, release from any liability, including civil liability, and agree not to sue any Affiliate, CVO, Medical Staff office or any of its authorized representatives, any Quality Affiliate and/or any Third Party or its officers, employees agents and authorized representatives, for any actions, recommendations, reports, statements, communications, or disclosures made in good faith involving me and related, but not limited, to the following: (i) applications for appointment or clinical privileges, including temporary privileges; (ii) periodic reappraisals undertaken for reappointment or for changes in clinical privileges; (iii) any Disciplinary Action; (iv) hearings and appellate reviews; (v) Affiliate and medical staff quality assessment/improvement activities; (vi) utilization reviews; (vii) any other Affiliate, medical staff, department, service committee activities; (viii) matters or inquiries concerning my Professional Information; (ix) any other matter that might directly or indirectly have an effect on my competence, on patient care, or on the orderly operation of these or any other healthcare facilities; (x) patient care audits; (xi) medical care evaluations, and (xii) reports to the National Practitioner Data Bank. This credentialing, quality assessment and utilization review activities.

Certification and Signature:
By applying for Medical Staff membership, AHP participation status and/or clinical privileges at the Affiliate, I accept all conditions, authorizations and releases set forth in this Authorization, Consent and Release regardless of whether I am granted membership, participation status or clinical privileges, and I intend to be legally bound thereby.

I UNDERSTAND THAT THE REJECTION OF MY APPLICATION FOR REASONS RELATED TO MY PROFESSIONAL CONDUCT OR COMPETENCE, WHICH REASONS INCLUDE THE MISREPRESENTATION, MISSTATEMENT OR OMISSIONS OF A RELEVANT FACT IN CONNECTION WITH MY APPLICATION, WHETHER INTENTIONAL OR NOT, SHALL CONSTITUTE CAUSE FOR THE AUTOMATIC TERMINATION OF MY APPLICATION PROCESS, DENIAL OF MY APPLICATION OR TERMINATION OR SUSPENSION OF MY MEDICAL STAFF MEMBERSHIP, AHP PARTICIPATION STATUS AND/OR CLINICAL PRIVILEGES AT THE AFFILIATE AND THAT THE REJECTION MAY BE REPORTED TO THE NATIONAL PRACTITIONER DATA BANK. I ACKNOWLEDGE THAT THE BURDEN OF PRODUCING REQUESTED DOCUMENTATION TO SUPPORT MY INITIAL APPLICATION AND ONGOING ELIGIBILITY FOR MEDICAL STAFF MEMBERSHIP, AHP PARTICIPATION STATUS AND/OR CLINICAL PRIVILEGES AT THE AFFILIATE IS MY RESPONSIBILITY. I HEREBY CERTIFY THAT THE INFORMATION I HAVE FURNISHED TO THE AFFILIATE OR THE MEDICAL STAFF AS PART OF MY APPLICATION IS CURRENT, TRUE, COMPLETE AND CORRECT. I AGREE THAT A PHOTOCOPY OF THIS DOCUMENT WILL SERVE AS A DUPLICATE ORIGINAL AND SHOULD BE CONSIDERED AN EXACT REPLICA OF THE ORIGINAL DOCUMENT.

I UNDERSTAND THAT I MAY REVIEW THE CREDENTIALING FILE RELATED TO MY APPLICATION MAINTAINED BY INDIANA UNIVERSITY HEALTH, INC. OR APPROPRIATE AFFLIATE, EXCEPT THAT I MAY NOT REVIEW ANY REFERENCES OR RECOMMENDATIONS OR OTHER PEER REVIEW PROTECTED INFORMATION. I ALSO UNDERSTAND THAT I MAY CORRECT ANY ERRONEOUS INFORMATION CONTAINED IN SUCH FILE IN ACCORDANCE WITH APPLICABLE POLICIES.

_____ _____

Signature Date

_____

Printed Name

08/27/2013

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