900 North Michigan Surgical Center

AUTHORIZATION AND RELEASE FORM

Your signature signifies that you agree to the following conditions pertaining to this application.

1) I attest to the correctness and completeness of all information furnished.
2) I am willing to appear for interviews in connection with this application.
3) I agree to abide by the terms of any bylaws, rules, regulations, policies and procedure manuals of 900 N. Michigan Surgery Center as presently formulated or as later amended or modified.
4) I release from any liability all those who, in good faith review, act on or provide information regarding my competence, professional ethics, character, health status and other qualifications for clinical privileges.
5) I authorize any healthcare facility to release copies of my privileges and staff application to 900 N. Michigan Surgery Center.
6) I authorize any medical school and healthcare facility to release any information on my medical training, internship, residency and fellowship to 900 N. Michigan Surgery Center.
7) I agree to provide the Medical Director of 900 N. Michigan Surgery Center any change in the information submitted in this application within thirty days of such change.

I hereby acknowledge that copies of the 900 N. Michigan Surgery Center bylaws are available in the business office of the Surgery Center, and available for my review at any time I deem necessary. I acknowledge that I will abide by these bylaws and any future additions or changes.

I hereby release from all liability all representatives of 900 N. Michigan Surgery Center and its Medical Staff for their acts performed in good faith and without malice in connection with evaluation of my application, credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to 900 N. Michigan Surgery Center 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.

I hereby authorize and consent to the release of any and all information pertaining to my professional liability insurance.

I hereby further authorize and consent to the release of information by 900 N. Michigan Surgery Center and its medical staff to the interested persons on request regarding any information 900 N. Michigan Surgery Center may have concerning me as long as such release of information is done in good faith and without malice. I hereby release from liability 900 N. Michigan Surgery Center and its staff for so doing.

Upon presentation of the original or photocopy of this signed authorization, I authorize any medical professional, hospital, clinic, professional malpractice insurance companies or other person or firm to provide 900 N. Michigan Surgery Center information, including copies or records, concerning my health and medical profession performance without limitation.

All information completed on this application and attached to this application is true and accurate to the best of my knowledge.

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Signature | Print Name | Date