Waiver of Liability and Consent
For Release of Information

I hereby request and consent to the release of information required in connection with my Application in the Memorial Hermann Health System centralized credential verification process to those hospitals, managed care organizations, health facilities, and other health care entities that I have specified in my application on the "Entity Designation Form."

I understand and acknowledge that, as an applicant for medical/allied health professional staff membership, society membership, or provider status in a managed care organization, at a hospital, health care entity, or other organization (hereafter referred to as "Entities"), indicated in this Application for Appointment/Application for Reappointment/Recredentialing (hereafter referred to as "Application."), it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my education, relevant training and/or experience, current license, current competence, health status, character, ethics and any other criteria adopted by Entities for medical/professional staff membership, clinical privileges, medical society membership, or managed care panel participation.

I further acknowledge that I am responsible for knowing the contents of the bylaws, rules and regulations of the Entities to which I have applied and agree to be bound by them if granted membership, privileges, or participation status.

1. I consent to and authorize the release of information concerning me to the MHHS by my college, medical school, or other educational institutions I have attended in accordance with the Family Educational Rights and Privacy Act of 1974 (FERPA). I further authorize release of information from hospitals, medical/professional staffs, other medical societies, grievance or imparted physician committee of a medical society, agencies of the government, board of medical examiners, national or state data banks, clinics, HMOs, PPOs, professional liability insurers with which I have been associated or currently have professional liability insurance or other types of health care organizations and institutions as long as such release of information is done in good faith and without malice. I understand that, from time to time, the MHHS will be updating contracted health care facilities with information related to me so that the health care facilities may review my staff membership or clinical privileges. I hereby consent to such updates and releases.
2. I hereby release from liability all representatives, members, employees, and agents of the MHHS from liability for their acts performed in good faith and without malice in connection with activities undertaken as part of the MHHS. I hereby further release from all liability and hold harmless all individuals, organizations, and agencies (including FSMB) providing information to the MHHS and for the MHHS' subsequent use of this information for use in credentials verification for its clients under the terms of this authorization.
3. A photocopy of this signed waiver of liability and consent for release of information shall be deemed to have my authorization and approval for release of the requested information to the MHHS. Information will be released by MHHS to those entities designated by me on the "Entity Designation Form" for purposes of verifying my credentials and for continuing medical staff quality reviews.

All information provided by me in the Application is true to the best of my knowledge, I understand that any misstatement in or omission from the Application may constitute grounds for denial of appointment or summary dismissal from the medical/professional staff and/or denial of medical society membership or managed care organization participation. I understand that the Entities shall be solely responsible for all decisions concerning medical/professional staff membership and the granting of medical and/or surgical privileges and that medical societies and managed care organizations shall also retain this responsibility.

I further acknowledge that I have read and understand the forgoing Waiver and Consent for Release of Information. A photocopy of this Waiver and release shall be as effective as the original and shall be valid from the date signed.

Printed/Typed Name of Applicant: _____

Signature of Applicant: _____ Date Signed: _____

Revised: 6/24/16