

AUTHORIZATION AND RELEASE OF INFORMATION

My electronic signature confirms that:

By applying for Medical-Dental Staff membership at Boston Medical Center, (BMC) I hereby signify my willingness to appear at BMC and to be interviewed in regard to my application if so requested.

I hereby authorize BMC to consult with any person(s) who may have information bearing on my competence, character and ethical qualifications and to inspect such records which shall be material to the evaluation of my professional qualifications and competence to carry out any clinical privileges I am requesting, as well as to my moral and ethical qualifications.

In accordance with Commonwealth of Massachusetts Regulations, if applicable, I hereby authorize the appropriate Board of Registration to supply BMC with a copy of any document requested.

I hereby authorize my malpractice insurer and all past malpractice insurers to provide BMC the following information as to claims or actions made or filed against me: policy number; name, address and age of the claimant or the plaintiff in the action; nature or substance of the claim; date and place where the claim arose; amounts paid, if any, and the date and manner of disposition, judgment, settlement or otherwise; date and reason for final disposition, if no judgment or settlement; and any additional information as may be reasonably requested by the BMC.

I hereby authorize any other facility where I have had education, training, employment, practice, or association for the purpose of providing patient care, or privileges to release to BMC any information, reasonably requested by it, that is relevant to my character, judgement and competence to perform any privileges I have requested.

I hereby authorize BMC to exchange information with any other health care facility and any professional organization with which I have had education, training, employment, practice, association or privileges, regarding any disciplinary action as defined by the Board of Registration in Medicine Regulations which includes, but is not limited to, any voluntary or involuntary course of counseling, treatment or testing for drug or alcohol abuse.

I hereby authorize BMC to provide copies of any and all portions of my application for Medical-Dental Staff membership relevant to the credentialing process required by any health maintenance organization, preferred provider organization, or other managed care entity or third party payer for whom the Hospital has agreed to provide health care services. This release shall not be construed to authorize the release of any information that is protected under the Peer Review Statute (G.L. c. 111, 204§ (a)).

I agree to undergo a medical or physical examination if requested by BMC and to provide evidence that any mental or physical impairment I may have does not interfere with my judgement or ability to perform any privileges I have requested.

I acknowledge that the burden of producing the necessary information for a proper evaluation of my competence, character, ethics or ability to perform and other qualifications shall be upon me.

I hereby release all individuals who submit information in connection with my application at the request of BMC and all representatives of the Hospital and the Medical-Dental Staff from any liability for statements made and acts performed in good faith and without malice in connection with my application and the processing thereof.

A photocopy or electronic image of my signature on this Authorization and Release of Information, Attestation, and any and all attachments has the same force and effect as the original.

ATTESTATION

My electronic signature confirms that:

I have reviewed the information in the *Application for Medical-Dental Staff Membership*, including all supplements and attachments, on the date indicated and it is true, complete, current, correct, and not misleading. In addition, while my application is being processed, I agree to update the information originally provided by me should there be any change in the information.

I have read and agree to comply with the BMC Code of Conduct.

I acknowledge that any misstatements or omissions (whether intentional or unintentional) from the *Application for Medical-Dental Staff Membership*, including all supplements and attachments, may constitute cause for denial of my application.

First Name Middle Name Last Name

Signature and Date (signed electronically)