CONSENT TO RELEASE OF INFORMATION AND RELEASE OF LIABILITY BY:

_____

(Name of Authorizing Physician)

Email Address: _____Specialty/Subspecialty:_____

Practice Address: _____Dates of Residency/Fellowship training:_____

Identity of Institution or Person requesting information : _____

(Requester)

PURPOSE: I am providing this request and consent in order to facilitate my application for employment by, admission into, licensure by, or credentialing by, the requester.

DEFINITIONS: "Requester" is the person or entity seeking information concerning me, and includes all of the requester's agents and authorized representatives so designated in writing. "The Department of Emergency Medicine" (hereafter "DEM"), the "The University of Texas Health Science Center at Houston" (hereafter "UTHSC") and The "UT System Medical Foundation" (hereafter "UTSMF" are the entities which I am authorizing to release information concerning me, and includes the Residency Program's Director, Chief Executive Officer, Administrative Personnel, Employees, Faculty, and Medical Staff.

REQUEST: I specifically request that DEM , UTHSC and UTSMF provide to the requester or any representative designated in writing by the requester, any and all information, documents, and records concerning my professional performance, competence, character, ethical qualifications, and behavior while an employee of DEM and UTSMF, specifically including the circumstances of my departure from DEM and UTSMF. I further specifically request that DEM, UTHSC and UTSMF provide such information whether it came into possession of that information prior to my employment, during my employment, or after my employment.

CONSENT AND AUTHORIZATION: I hereby authorize the requester identified above, or any representative designated in writing by that requester, to consult with DEM, UTHSC and UTSMF, its Program Director, Chief Executive Officer, Administrative Personnel, Employees, Faculty, and Medical Staff in order to obtain any and all information regarding my professional competence, character, ethical qualifications, behavior while an employee of DEM and UTSMF, and circumstances of my departure for DEM and UTSMF. I hereby consent to the release of any and all information, records, documents, and/or opinions that DEM, UTHSC and UTSMF, may determine, in its sole discretion, to provide to the requester pursuant to this authorization. I further consent to the copying by DEM , UTHSC and UTSMF, and transmittal to the requester or its representatives, of any and all records, documents, and/or opinions described in the paragraphs above, as well as any other information, documents and/or opinions that may be material to an evaluation of my professional qualifications and competence to practice medicine, my qualifications to obtain or hold clinical privileges or professional credentials, and my moral and ethical qualifications for employment. I hereby consent to the consultation and to the provision of information, records, documents, and/or opinions described above to the requester now, or at any time in the future, in the event of a subsequent inquiry or request. I further consent to a supplemental consultation and to the provision of supplemental information, records, documents, and/or opinions at any time in the future in the event that DEM/UTHSC/ UTSMF, in its sole discretion, determines for any reason that information or opinions it has previously provided pursuant to this release are no longer complete, accurate, or timely, or that such information should be amended to make it more complete, accurate, or timely.

WAIVER OF LIABILITY: I hereby release the requester, DEM, UTHSC and UTSMF, and their respective representatives, from all liability, to the fullest extent permitted by the law, for any and all acts performed under this authorization, specifically including the provision of information, documents, or records pursuant to this request.

RELEASE AND WAIVER OF ALL CLAIMS: I specifically waive any claim for damages of any kind against DEM ,UTHSC and UTSMF, for acts performed pursuant to this authorization, to the fullest extent permitted by the law, including but not limited to claims of interference with contract, invasion of privacy, defamation, slander, discrimination, denial of employment, admission, licensure, or credentials, or negligence of any kind in the communication of such information to the requester or its representatives.

HOLD HARMLESS AND INDEMNIFICATION: I hereby agree to hold DEM, UTHSC and UTSMF, and their representatives harmless from any and all claims made against it by me, the requester, or any other person or entity as a result of the release of information, documents, or records pursuant to this authorization. Specifically included in "hold harmless and indemnification" within this paragraph are any claims arising from denial of employment, admission, or credentials to me by the requester or its representatives. I further specifically agree to indemnify DEM, UTHSC and UTSMF, and their representatives for any and all legal fees, costs, or any other expenses incurred in defending any claim arising from the release of information, records, or documents sought by this request or provided pursuant to this authorization.

_____ _____ _____

Signature of Authorizing Physician Date Print Legal Name of Authorizing Physician