

CONSENT / AUTHORIZATION FOR RELEASE OF INFORMATION

This form will not be accepted if altered, modified, illegible or incomplete

By signing this Authorization, I consent to the inspection by **Baptist Healthcare System**, or its representative, **AccuCheck Inc.**, of all records and documents that may be material to an evaluation of my professional qualifications, credentials, clinical competence, character, general reputation, ethics, behavior, or any other matter that may be considered material to my qualification or re-qualification for affiliation, appointment or employment (including contract for services). I understand that this investigative consumer report may include the inspection and/or verification of any information provided to the above named sources in the form of an application, CV or resume, or information gained from third party informants including the following sources: educational and training records, professional organization or association records, civil and criminal court records, public local, county, state or federal court records, licensing boards, certifying boards and agencies, regulatory agencies, insurance claims history records, driving records, contact with references and any other records or third parties that may have information bearing upon my application. Additionally, I hereby consent to the release of my military personnel records and related medical records and I authorize the National Personnel Records Center, or other custodian of my military records to release the information and/or copies of documents from my military service record.

Contact with, and information provided from the above sources delineates the nature and scope of the investigative consumer report prepared by AccuCheck Inc. I acknowledge that I may receive a written summary of my rights pursuant to the Fair Credit Reporting Act (FCRA) 15 USC §. 1681 et. seq., (also available online from the Federal Trade Commission at <http://www.ftc.gov/os/statutes/fcra.htm>).

I hereby release from liability all representatives and agents of the aforementioned organizations for their acts performed in good faith and without malice in connection with evaluating my application. I provide my consent and authorize any of the aforementioned sources to furnish information and/or verification of information as requested.

I acknowledge that a copy of this Authorization for Release of Information shall be as binding as the original.

Print full name

Manual Signature

Date of Signature

I acknowledge that the identifying information requested below is for purposes of receipt, review and proper identification of any/all source information as outlined above. Personal identifying information (information below this sentence) will not be provided to any sources (ie: peer references, etc.) that do not require same for verification purposes.

Print Name as commonly used (if different than above)

Social Security # / Social Insurance # (if none specify "none" above)

Date of Birth (month / day / year)

Gender (specify Female or Male)

Drivers License # (exactly as it appears on Drivers License)

State issuing Drivers License

0-

ECFMG Certification # (if applicable)

List former names; first and last names (maiden names, nicknames, etc...)

PRACTICE LOCATIONS (full seven year history) – list all locations of practice; continue on separate piece of paper if needed

hospital name and/or office	location (city/state)	County	(to present) dates
hospital name and/or office	location (city/state)	County	(to) dates
hospital name and/or office	location (city/state)	County	(to) dates

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AccuCheck Inc., abides by and complies with applicable federal laws as provided in the Fair Credit Reporting Act (FCRA) governing an investigative consumer report, as well as the FACTA Disposal Rule regarding use, storage and disposal of private information contained herein.