CONSENT FOR REVIEW AND RELEASE
OF INFORMATION AND DOCUMENTATION
AND
LIABILITY RELEASE

I, (________________________________), have submitted an application for appointment to the professional staff of Center for Health Ambulatory Surgery Center, LLC., Central Illinois Endoscopy Center, Graham Health System, Methodist Medical Center, Proctor Hospital, OSF Saint Francis Medical Center, OSF Saint James-John W. Albrecht Medical Center, Proctor Health Systems, Inc/Proctor First Care, Peoria Ambulatory Surgery Center, Peoria Day Surgery Center, Fayette Companies(Human Service Center/White Oak Companies), and the Renal Intervention Center which is being processed through the Peoria Medical Society. I hereby authorize the Peoria Medical Society, its officers, members and employees and the hospital or hospitals to which I am making application and their respective medical staffs, officers, directors, employees and representatives to consult, correspond with, and otherwise communicate with governmental officers or agencies and any individual having knowledge of me for the purpose of gathering information and documentation bearing upon my education, professional competence, character and ethical qualifications. I consent to the inspection, recording and copying by the Peoria Medical Society, the hospitals to which I am making application and their representatives of all records and documents which may be material to my education, professional competence, character and ethical qualifications.

I hereby authorize any and all hospitals, clinics, health care facilities, schools or other institutions, governmental officers or agencies, and all individuals having knowledge of me, whether or not identified by me on the application, to release documents and information, including copies, summaries or complications thereof, and to communicate verbally or in writing or both any information or evaluation concerning my education, professional competence, character or professional ethics, including otherwise privileged or confidential information. This authorization is for release of documents and information to the Peoria Medical Society and the above-named hospital(s) to which I am making application. To the extent this information is communicated to Peoria Medical Society, I further authorize Peoria Medical Society to release and communicate such documents and information obtained to the respective named hospitals to which I am making application to be used by such hospital or hospitals in evaluating my application. This release shall extend to, without in any way limiting the foregoing, any records or information concerning disciplinary actions and suspension or curtailment of surgical/medical privileges involving myself.

I hereby release from any and all liability of whatever kind, each and every institution, agency or individual providing documents or information pursuant to this consent, the Peoria Medical Society, the hospitals to whom I am making application, and their respective medical staffs, officers, directors, employees and representatives for their acts performed in connection with the inspection, communication, delivery, receipt, evaluation or other use of information and documentation as herein consented to by me in connection with the processing, evaluation or decision upon my application.

A photocopy of this waiver shall be as effective as the original when so presented.

NAME: ____
Print or Type

SIGNATURE: _______________________________________

DATE: ___________________________