

Authorization and Release:

PhyAmerica Government Services, Inc. its subsidiaries and affiliates and their employees and representatives (collectively referred to as “you”), are hereby authorized to consult with the employees and medical staff members of any medical facility with which I have been associated and with such other individuals or organizations including past and present malpractice insurance carriers, state medical boards of which I have been a member, private practitioners, hospitals with which I have been associated and schools I have attended or others in order to obtain information bearing on my academic record, professional performance or other evaluations. I hereby release and discharge you and any other individuals or organizations providing such information and any and all persons, employees, representatives or agents of any of the above from any and all liability or claims of any nature in connection with the information furnished hereunder. I further consent to the release of information obtained to your client hospitals, clinics and healthcare providers. I understand that it may be difficult to obtain the background information unless it is solicited in a confidential manner. I understand and agree that I will not have access to this information and I waive any right of access to such information that I may have under the laws of any state or of the United States except as may be required by court order. A copy of this Authorization and Release may be provided to each individual, hospital and organization where information on my credentials is sought and shall remain in effect until specifically revoked in writing by me.

Typed or printed name of applicant: _____

Signature of applicant: _____ Date: _____