AUTHORIZATION AGREEMENT

I hereby authorize Duke University Health System (DUHS), the medical staff(s) at DUHS-operated facilities and their representatives to consult with administrators and members of the medical staff of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my clinical competence, character, and ethical qualifications. I also consent to the inspection by Duke University Health System, the medical staff(s) at DUHS-operated facilities and its representatives of records and documents that may be material to an evaluation of my qualifications for staff membership. I hereby release from liability any and all individuals and organizations who provide, in good faith, information to Duke University Health System or the medical staff(s) at DUHS-operated facilities, and I hereby consent to their release of such information to all personnel involved in the credentialing process at any other facility to which the applicant has applied and which is a part of the Duke University Health System. This consent extends to the solicitation of information by and the provision of information directly to GetProof Inc. d/b/a/ Vision CVO, who will be providing primary data search and collection and other services related to medical credentialing and re-credentialing on behalf of DUHS and facilities operated by DUHS.

I understand that additional information concerning my health may be required for the consideration of this application, and that my health as it relates to my ability to perform my medical staff duties appropriately will be an ongoing consideration.

I agree that my activities as a member of the medical staff will be bound by the provisions of the Institutional Bylaws, Rules & Regulations, and Code of Conduct. I understand that any significant misstatement in or omission from this application will constitute cause for immediate denial of appointment or summary dismissal from this Program.

I consent to the release of information provided in this application to any insurance plan in which DUHS, or a component of DUHS, is a participating entity, subject to DUHS receiving from the plan an authorization for the release of such information, which I have executed.

I hereby declare that the statements in this application and all attachments hereto are complete and accurate.

_____ _____

Signature of Applicant **Date**