

Yale-New Haven Hospital

Authorization to Release Records and Information

By applying for appointment/reappointment as a Clinical Fellow on the Yale-New Haven Hospital Medical Staff, I hereby authorize Yale-New Haven Hospital, its representatives, employees, agents and members to consult with prior associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, and ability to work cooperatively with others.

I hereby release from liability all representatives, employees, agents and Medical Staff members of Yale-New Haven Hospital, for their acts performed and statements made in connection with evaluating my credentials and qualifications.

I hereby release from liability any and all individuals and organizations who provide information to Yale-New Haven Hospital, its representatives, employees, agents and members concerning my professional competence, ethics, character, and other qualifications for membership.

I agree to indemnify Yale-New Haven Hospital, its representatives, employees, agents and Medical Staff members in the event that any false or misleading information or failure to provide complete data later exposes the Hospital to professional liability.

I authorize Yale-New Haven Hospital and its employees and agents to allow Delegated Entities and/or Accrediting Bodies access to my provider credentialing and recredentialing files as requested and to permit Delegated Entities and/or Accrediting Bodies to review said files.

I agree to abide by the Bylaws and the Rules & Regulations of the Medical Staff of Yale-New Haven Hospital. (Copies of the Bylaws are available upon request or via the Y-NHH Clinical Workstations. A copy of the Rules & Regulations is attached.) I further agree to abide by the Policies applicable to my activities and to provide for continuous care for my patients. Additionally, I agree to practice in accordance with my privileges as delineated and to obtain consultations as appropriate.

I further attest that I have read, understand and will abide by the enclosed Y-NHH policy regarding Infection Control and Safety Precautions.

I declare under penalty of law, that all statements, answers, and information contained in this application are true, correct and complete to the best of my knowledge. I understand that falsification, misrepresentation or omission of any fact(s) will be sufficient cause for ceasing processing and/or denial of this application and/or subsequent termination of any participating privileges granted upon the basis of this application with no hearing rights. I agree to inform Yale-New Haven Hospital in writing within fifteen (15) days, of any changes in the information provided and the answers to questions on the application as a result of new information or developments subsequent to my signing of the application.

I understand and agree that acceptance of this application/reappointment application does not constitute approval of membership in the Yale-New Haven Hospital Medical Staff and grants me no rights or privileges of membership until such time as I receive written notice of membership status.

I agree that photocopies of this document will be as binding as the original and attest to the fact that the signature below is my own.

(Date)

(Signature of Clinical Fellow)

(Printed Name)