# Standard Authorization, Attestation, and Release

**(PLEASE READ CAREFULLY BEFORE SIGNING)**

In connection with this application for participation in the HWMG Provider Network, which is owned and operated by Hawaii-Western Management Group (HWMG), I understand and acknowledge it is the hospital/facility's responsibility to provide sufficient information upon which a proper evaluation can be undertaken of the hospital/facility's current licensure, ethics and any other criteria adopted by HWMG for Participation.

On behalf of the hospital/facility, I further acknowledge the hospital/facility is responsible for knowing the contents of the applicable rules and regulations, and requirements of HWMG and its professional/medical staff/network, and agree to be bound by them in the application process and if granted Participation. I agree to have the hospital/facility participate in the HWMG Provider Network and understand an agreement is not effective until accepted by HWMG.

1. **Authorization of Investigation and Release of Information Concerning Application for Participation.** I authorize HWMG and its Agents to consult with any third party who may have information bearing on the hospital/facility's professional qualifications, credentials, ethics, or any other matter reasonably having a bearing on the hospital/facility's qualification for Participation and authorize such third parties to release such information to HWMG and/or its Agents.
2. **Authorization of Release and Exchange of Disciplinary Information.** I hereby further authorize any health care organization at which the hospital/facility has applied for, currently have or had Participation to release Disciplinary information about any disciplinary action taken against the hospital/facility to HWMG and/or its Agents, and as otherwise may be required by law. I hereby further authorize HWMG to release Disciplinary information about any disciplinary action taken against the hospital/facility to its participating entities at which the hospital/facility has Participation, and as otherwise may be required by law. As used herein, Disciplinary Information means information concerning (i) any action taken by such health care organization, their administrators or their medical or other committees to revoke, deny, suspend, restrict or condition the hospital/facility's Participation or impose a corrective action plan; (ii) any other disciplinary actions involving the hospital/facility including but not limited to discipline in the employment context; or (iii) the hospital/facility's registration prior to the conclusion of any disciplinary proceeding or prior to the commencement of formal charges but after the hospital/facility has knowledge that such formal charges are contemplated and/or in preparation.
3. **Release from Liability.** I hereby further release from liability HWMG and its Agents, state licensing board(s), health care organizations, including, without limitation, hospitals, clinics, and third party payers, medical malpractice insurance carrier(s), and any staff, and all individuals, institutions and entities providing information in accordance with this authorization, for their acts performed in good faith and without malice in connection with the gathering and release and exchange of information as consented to above. This release shall be in addition to any other applicable immunity provided by law for peer review activities.

I understand and agree that HWMG may communicate with me via e-mail over the internet regarding my application for credentialing. I understand that unencrypted, unauthorized Internet e-mail is inherently insecure. I further understand that Internet messages may be corrupted or incomplete, or may incorrectly identify the sender.

I understand and agree this Authorization and Release is irrevocable for any period during which the hospital/facility is an applicant for Participation with HWMG. I agree to execute consent if law or regulation limits the application of this irrevocable authorization. Failure to promptly provide consent may be grounds for termination or discipline by HWMG in accordance with the applicable bylaws, rules and regulation, and requirements of HWMG.

I acknowledge that the investigation of information in this application and the release and exchange of Disciplinary Information by HWMG and its Agents are done to achieve, maintain and improve quality patient care.

I certify that all information provided by me in this application is true, correct, and complete to the best of my knowledge and belief. If there are any changes to the information, I will notify HWMG within thirty (30) days of any changes to the information.

I understand and agree that any material misstatement in or omission from this application may constitute grounds for denial or revocation of Participation. I understand and acknowledge that HWMG shall be solely responsible for all decisions concerning the granting of Participation.

I further acknowledge I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization, Attestation, and Release shall be as effective as the original.

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| ______________________ | ______________________ | __________ |
| Name of Authorized Representative (print) | Signature | Date |
| ______________________ | ______________________ | |
| Job Title | Hospital/Facility Name | |