



CONSENT TO RELEASE INFORMATION

I, _____, (print name) have applied for appointment to the University of Rochester Strong Memorial Hospital as a medical or dental trainee. I understand that the University of Rochester Medical Center’s Graduate Medical Education Office (hereafter referred to as URMG GME Office) administers a centralized credentialing verification service. I agree to have the URMG GME Office process my application.

In connection with my application, I consent to the URMG GME Office and all entities where I have privileges or have made application for privileges to report, release, and exchange information among themselves and with or to (a) the Secretary of the Department of Health and Human Services; (b) the Medical Board of the State of New York; or (c) any other person or entity required by law related to the following: (1) any payments made for my benefit under a policy of insurance, self-insurance, or otherwise in settlement or partial settlement of, or in satisfaction of a judgment in, a medical malpractice action or claim; (2) any professional review action or formal disciplinary procedure that adversely affects my clinical privileges, including the reduction, restriction, suspension, revocation, denial or failure to renew such privileges, for a period longer than 30 days for reasons relating to my professional competence or conduct; (3) any surrender of clinical privileges accepted by a healthcare entity relating to possible incompetence or improper professional conduct, or any surrender of clinical privileges accepted by a health care entity in return for not conducting such investigation or proceeding; (4) any professional review action of a professional society which adversely affects my membership in the society; (5) any surrender of my license(s) or censure, reprimand, or probation by the board of Medical Examiners of any state for reasons relating to my professional competence or professional conduct and (6) any other information which may be required by law.

I further consent to the URMG GME Office and their representatives to consult with administrators and members of the medical staffs of hospitals or institutions with whom I have been associated and with other entities or persons, including past and present malpractice carriers, who may have information bearing on my professional training, competence, character, mental and physical health status, and ethical qualifications. I also consent to the URMG GME Office and their representatives, inspecting all documents that may be material to an evaluation of my professional qualifications and competence (my medical school, previous medical or training programs, and the ECFMG as applicable, as well as any employer since medical school graduation) to carry out the clinical privileges required of my medical or dental training program, as well as my moral, mental health, and ethical qualifications.

I hereby release from liability all representatives of the URMG GME Office and any other persons providing information for their acts performed in good faith, without malice and in reasonable belief that any information gathered, exchanged, or released is warranted by the facts known to them.

I understand and agree that this consent is irrevocable (a) for as long as the URMG GME Office may be under duty to report information regarding me pursuant to the Health Care Quality Improvement Act of 1986, Pb. I.99-660 or any other applicable law.

All information submitted by me in the general application form or through ERAS (Electronic Residency Application Service) is true to the best of my knowledge and belief. I fully understand that any misstatement in, or omission from, the application (general form or ERAS) may constitute cause for denial of appointment or cause for summary dismissal. I also authorized the URMG Security ID Office to release my identification photo to the URMG GME Office and to my training program.

By applying for appointment to be a medical or dental trainee, I acknowledge that I have received and have the responsibility to read the Resident and Fellow Manual which can also be found at <http://www.urmc.rochester.edu/smd/gme/ResidentManual/index.cfm>. I agree to be bound by the terms of such documents as well as other applicable policies that may from time to time be in effect as well as the policies of my training program. I agree to conduct myself in accordance with the ethical principles of the American Medical Association or other applicable professional association, and I pledge to provide safe and quality care for my patients.

Applicant’s Name (Please print)

Date

Applicant’s Signature