



RELEASE OF INFORMATION

I hereby authorize Florida Health Care Plans with whom I am seeking to be appointed, reappointed, or associated, and their authorized representatives to consult with the management and members of the medical staffs of other institutions with which I am or have been associated, past and present malpractice insurance carriers; and all others who may have information with regard to my professional competence, credentials, character, ethical qualifications, mental or emotional stability and physical condition. I further authorize them to inspect all records and documents, including my personnel files and the medical records of my patients at other hospitals (so long as all patient identifying information is redacted) that may be material to such questions.

I hereby release from liability any and all individuals and organizations, and their authorized representatives, for statements made, materials provided or acts performed in good faith while responding to an inquiry.

This authorization shall remain in effect during my association with, appointment to, or reappointment to, Florida Health Care Plans.

Applicant's Name

Applicant's Signature

Date