

RESIDENT CREDENTIALING VERIFICATION
AUTHORIZATION AND RELEASE FOR INFORMATION
Texas Tech University Health Sciences Center

I hereby CONSENT for and AUTHORIZE Texas Tech University Health Sciences Center ("TTUHSC") to RELEASE relevant information to credentialing agencies including, but not limited to, hospitals, medical boards, residency and fellowship training programs, other entities and individuals ("Requestor") regarding my activities as a physician, faculty member, fellow or resident physician ("Physician") while employed by or serving at TTUHSC.

1. When submitting a Request for Information, Requestor SHALL include a signed and dated consent for Release of Information from the Physician made the subject of the Request for Information.
2. Upon receipt of a Request for Information from Requestor, TTUHSC SHALL contact Physician, and Physician SHALL contemporaneously sign, date and provide TTUHSC this Authorization and Release for Information. TTUHSC SHALL NOT forward the requested information to Requestor until such time that TTUHSC receives from Physician this contemporaneous, signed and dated Authorization and Release for Information.

I hereby release TTUHSC and its employees, agents, and personnel who, in good faith, are acting on behalf of TTUHSC from any and all liability associated with the release of information referenced in this Authorization and Release for Information.

I represent that I am at least eighteen (18) years of age and that I have read this document and understand its contents.

PHYSICIAN'S NAME (*print*) _____

PHYSICIAN'S NAME (*signature*) _____

STREET ADDRESS _____

CITY, STATE, ZIP CODE _____

PHONE (W) _____

PHONE (H) _____

DATE _____