advanced care providers

Disclosure and Release

In connection with my application for consideration of staffing assignments (including contract for services) with Advanced Care Providers (ACP) to Health Care Facilities (Entities), I understand that a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment/contractor purposes will be conducted. I understand that it is my responsibility to produce adequate information for a complete evaluation of my qualifications. I understand that the scope of the consumer report/investigative consumer report may include, but is not limited to, the following areas: Verification of social security number; current and previous residences; employment history including personnel files; education including transcripts; character references; criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; birth records; motor vehicle records to include traffic citations and registration; past malpractice insurance coverage and related judgments I may have been involved in; and any other public records; or to conduct interviews with third parties relative to my character, general reputation, or work ethics and performance.

I further authorize any individual, company, firm, corporation, or public agency (including the Social Security Administration and law enforcement agencies) to divulge any and all information, verbal or written, pertaining to me to ACP or its agents and Entities. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources.

I hereby release ACP, the Entities, the Social Security Administration, and its agents, officials, representatives, or assigned agencies, including officers, employees, or related personnel both individually and collectively, from any and all liability for damages of whatever kind, which may, at any time, result to me, my heirs, family, or associates because of compliance with this authorization and request to release. You may contact me as indicated below.

I hereby authorize procurement of consumer report(s)/investigative consumer report(s). If hired or contracted, this authorization shall remain on file and shall serve as ongoing authorization for ACP to procure consumer report(s)/investigative consumer report(s) at any time during my employment (or contract) period and to provide information to medical facilities I currently am credentialed at or facilities I agree to apply for credentialing and privileges. I understand I have the right to revoke the authorization at any time, provided I do so in writing.

By applying for the affiliations requested, I accept the following conditions regardless of whether or not I am granted appointment or privileges, and intend to be legally bound thereby. These conditions shall remain in effect for the duration of any term of any and all appointments I may be granted.

To the fullest extent permitted by law, prior to and throughout any period of my affiliations with the Entities, I extend absolute immunity to, release from any and all liability, and agree not to sue ACP, the credentialing service, the Entities, their authorized representatives, and/or 3rd parties who provide information for any matter relating to my application for appointment or my qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, or disclosures involving me, which are made, taken, or received by ACP, the credentialing service, the Entities, their authorized representatives, and/or 3rd parties in the course of credentialing and peer review including but not limited to: applications for appointment or clinical privileges, including interim or temporary privileges; periodic reappraisals undertaken for reappointment or for increase or decrease in clinical privileges; proceedings for suspension or reduction of clinical privileges for denial or revocation of reappointment, or any other disciplinary action; hearings and appellate reviews; quality assessment/improvement activities; utilization reviews; other Entity committee activities; matters or inquiries concerning professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, or behavior; and any other matter that might directly or indirectly disrupt the orderly operation of the Entities or any other hospital or health care entity.

I authorize ACP, the Entities and their authorized representatives to consult with any 3rd party who may have information bearing on my professional qualification (credentials), clinical competence, character, judgment, mental or emotional stability, physical condition, ethics, or behavior, bearing on my qualifications for appointment to the medical staff and/or Network (such information is referred to herein as "Credentialing Information"). This authorization includes the right to inspect and to obtain any and all documents, recommendations, reports, statements, or disclosures relating to such Credentialing Information. I expressly authorize said 3rd parties to release Credentialing Information to the Entities, and their authorized representatives upon request. I also expressly authorize the Entities to release Credentialing Information to any medical clinic or other Entity at which I am employed, seeking employment or contracted with as a health care provider.

Name (print): _____ Date: _____

Signature: _____

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Health Information Privacy & Consent Confidentiality Statement

With the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), personally identifiable healthcare records came under a new and heightened level of confidentiality. In the regular course of business, Advanced Care Providers (ACP) interacts and communicates directly with candidates who may share their personally identifiable information. In turn, we collect, store and process the information electronically and/or manually. With the belief that it is a person's right to have their personal information kept private, ACP conducts business with respect for and in compliance with all applicable health information privacy laws, including but not limited to HIPAA. We respect our legal obligation to implement privacy procedures and technical security measures to keep your personal information private and secure. As we are obligated to give you notice of our privacy practices, the statement of policies and protocols which follows describes how our staff may use and disclose your medical information and how you may get access to this information and relative accounting. After reviewing the information carefully, please complete, sign, and date this form, then return it via fax or mail to the addresses listed at the end of this statement.

For the purpose of this document and for employment through ACP, your "health information" includes the following items that we request on behalf of our facility clients:

- Annual physician's or health record statement
- Documentation used to prove immunity to measles, mumps, and rubella [laboratory titers or records of MMR injection(s)]
- Documentation used to prove immunity to Varicella [laboratory titer, record of Varivax immunization, or immune by history statement]
- Documentation used to prove immunity to HBV [laboratory titer or record of HBV immunization series] or a declination statement thereof
- Annual tuberculosis screening [PPD test results or chest x-ray reading]
- Pre-placement drug screening [conducted by ACP or contracted facility]

Generally, we cannot use your health information or disclose it outside of our office without your written permission. The written permission comes from your completed consent form. We ask you to sign the consent form allowing us to use and disclose your health information for purposes of submittal to client facilities, of assignment to job openings at client facilities, and continued employment through ACP at client facilities. For example, your health information may be sent via fax or email to a client representative either for submittal consideration or to confirm placement. Facility representatives [HR managers, nursing officers, unit managers or medical staff services] will review your health information to evaluate whether or not you meet their standard immunization requirements set forth for temporary staff. An ACP representative will advise you of any necessary medical documentation for placement. Any variation from the facility standard may delay or cancel an assignment. We may refuse to place you if you do not sign the consent form. At times, client facilities may request further documentation than the above defined "health information" of a candidate's health and immunization records to comply with state or local regulations. At those instances, an ACP representative will advise you of the requirements and request your consent for that additional information.

The law gives you many rights regarding your health information. You may request photocopies of your health information, an amendment to any incorrect or incomplete information, additional copies of this notice, or a list of the disclosures we have made of your health information. ACP reserves the right to change this statement at any time in compliance with and as allowed by law. If we make any changes, the new policies and protocols will apply to your health information that we already have as well as to such information that we may generate or request in the future. We will send out notices of any changes via mail and post them in our office and on our website www.ACPstaff.com. If you should have any questions concerning ACP privacy practices or wish to access or correct private information collected from you, please contact our HIPAA Privacy Officer via mail, phone, fax, or email: MAIL: PO Box 972, Minocqua, WI 54548 PHONE: 715-661-0030 FAX: 323-375-3290 EMAIL: mike@ACPstaff.com

I confirm that I have read, understand, and consent to the policies and protocols regarding disclosure and transmission of information as outlined in this statement regarding my health information.

Name (print): _____ Date: _____

Signature: _____