Centralized Credentials Verification Service
Consent and Release from Liability Statement *

I, _____ (please print full name), hereby authorize the DHA Centralized Credentials Verification Service (DHA CCVS) staff to consult with administrators and members of any facility, hospitals, or institutions with which I have been associated, and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character, and ethical qualifications.

I hereby further consent to the inspections by the DHA CCVS, the clinical staff and their representatives of all records and documents (not otherwise restricted) at other hospitals and facilities that may be material to an evaluation of my professional qualifications and competence.

I hereby release from liability any and all individuals and organizations that, in good faith and without malice, provided any and all information to the officials of the DHA CCVS, including medical facility officers or to the authorized medical staff representatives, concerning my professional practice, competence, ethics, character and other qualifications for staff appointment and clinical privileges.

I hereby consent to the release of any and all such information to the DHA CCVS.

_____ _____

Type or Printed Name of Applicant | Date

_____ XXX-XX-_____

Signature of Applicant | Last Four SSN of Applicant

* Consent/ Release must be included with any verification request submitted.