

PHYSICIAN LICENSING SERVICE

132 EAST 13056 SOUTH, SUITE 100 DRAPER, UT 84020
PHONE 1-888-551-2140 ~ FAX 801-816-1207

AUTHORIZATION AND RELEASE

I, _____, hereby authorize the following entities to release all information, files, transcripts, or records to state licensing boards and/or **Physician Licensing Service**, for the purpose of evaluating my professional, ethical, and physical qualifications for medical licensure and/or employment:

All medical institutions and organizations, specialty boards, educational institutions, medical societies, physicians, nurses, health care professionals, employers, malpractice insurance carriers, licensing boards, government agencies and instrumentalities (local, state, federal, or foreign), professional and business associates, personal references, attorneys, the Federation of State Medical Boards, the Federation Credentialing Verification Service and the National Practitioner Data Bank.

I, the undersigned, waive any privileges of confidentiality of information required by the aforementioned entities for the purposes indicated herein. This form shall authorize and request state medical boards to send all letters of deficiency and status correspondence to Physician Licensing Service.

I hereby release the aforementioned entities from all liability for the release of this information. The original or a copy hereof shall operate as full proof of authority and release.

(Signature)