

**UNIVERSITY OF MICHIGAN HEALTH SYSTEM
PHYSICIAN AUTHORIZATION FOR RELEASE OF CREDENTIALING
AND PRIVILEGING INFORMATION**

I, _____ authorize and release from liability the University of Michigan Health System(UMHS), who in good faith and without malice, provides necessary information for the verification of my professional credentials and UMHS Medical Staff privileges to an external health care organization/provider in order to provide telemedicine services to that external organization/provider.

I hereby release from liability all individuals and organizations who provide information concerning my qualification for staff appointment and clinical privileges. I further release from liability the requesting institution, its staff, officers and employees who make inquiries concerning consideration, award or denial of my application.

Signature

Date

Note: This authorization is in effect until expiration of service delivery contract or the physician's anniversary date, whichever is shorter.