Hawaii Residency
PROGRAMS, INC.

The Queen's Medical Center · Kapi'olani Medical Center for Women & Children · Straub Medical Center · Pali Momi Medical Center
Kuakini Medical Center · Wahiawa General Hospital · Kaiser Foundation Hospital · University of Hawai'i at Manoa, John A. Burns School of Medicine

Consent to Release Information (for Notary in Hawaii)

Instructions

- ☐ Complete 'Consent to Release Information' Form.
- ☐ Maximum of 5 entities per consent form
- ☐ Obtain Notary Certification of the form.
- ☐ Attach applicable fee and submit form to Residency Program.
- ☐ Notify the entities requesting the information that the entity must send a direct request to the Program (email, fax, paper). No information will be provided otherwise.
- ☐ After completion of ALL above steps, the Program will send requested information DIRECTLY to the requester. Information is not sent to the Trainee or Former Trainee.

Processing Fee

- ☐ Residents/Fellows in training, under contract with Hawaii Residency Programs, at the time of request
  - Fee is waived
- ☐ Former Residents/Fellows
  - Fee= $50 per institution/person
- ☐ NOTE: The fee is waived if the Institution requesting information is a major participating hospital within Hawaii Residency Programs:
  - Kapi'olani Medical Center for Women and Children
  - Straub Medical Center
  - Pali Momi Medical Center
  - Queen's Medical Center
  - Kuakini Medical Center
  - Wahiawa General Hospital
  - Kaiser Permanente (Hawaii Region)
  - State of Hawaii Department of Health
  - Department of Veterans Affairs (Hawaii Region – Spark M. Matsunaga VA Medical Center)
  - John A. Burns School of Medicine

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($50 fee per response to each Institution or Person and made payable to *Hawaii Residency Programs, Inc.*)

HRP Use Only:
☐F ☐M

CONSENT TO RELEASE OF INFORMATION AND RELEASE OF LIABILITY BY:

_____
(Name of Authorizing Physician)

Email Address: _____ Specialty: _____ Subspecialty: _____

Practice Address: _____ Dates of Residency training: _____

Identity of Institution or Person requesting information: _____
(Requester – Maximum of 5 per consent form)

PURPOSE: I am providing this request and consent in order to facilitate my application for employment by, admission into, licensure by, or credentialing by, the requester.

DEFINITIONS: "Requester" is the person or entity seeking information concerning me, and includes all of the requester's agents and authorized representatives so designated in writing. "Hawaii Residency Programs, Inc." (hereafter "HRP") and the "University of Hawaii" (hereafter "UH") are the entities which I am authorizing to release information concerning me, and includes the Residency Program's Director, Chief Executive Officer, Administrative Personnel, Employees, Faculty, and Medical Staff.

REQUEST: I specifically request that HRP and UH provide to the requester or any representative designated in writing by the requester, any and all information, documents, and records concerning my professional performance, competence, character, ethical qualifications, and behavior while an employee of HRP, specifically including the circumstances of my departure from HRP. I further specifically request that HRP and UH provide such information whether it came into possession of that information prior to my employment, during my employment, or after my employment.

CONSENT AND AUTHORIZATION: I hereby authorize the requester identified above, or any representative designated in writing by that requester, to consult with HRP and UH, its Program Director, Chief Executive Officer, Administrative Personnel, Employees, Faculty, and Medical Staff in order to obtain any and all information regarding my professional competence, character, ethical qualifications, behavior while an employee of HRP, and circumstances of my departure for HRP.

I hereby consent to the release of any and all information, records, documents, and/or opinions that HRP and UH may determine, in its sole discretion, to provide to the requester pursuant to this authorization. I further consent to the copying by HRP and UH, and transmittal to the requester or its representatives, of any and all records, documents, and/or opinions described in the paragraphs above, as well as any other information, documents and/or opinions that may be material to an evaluation of my professional qualifications and competence to practice medicine, my qualifications to obtain or hold clinical privileges or professional credentials, and my moral and ethical qualifications for employment.

I hereby consent to the consultation and to the provision of information, records, documents, and/or opinions described above to the requester now, or at any time in the future, in the event of a subsequent inquiry or request. I further consent to a supplemental consultation and to the provision of supplemental information, records, documents, and/or opinions at any time in the future in the event that HRP/UH, in its sole discretion, determines for any reason that information or opinions it has previously provided pursuant to this release are no longer complete, accurate, or timely, or that such information should be amended to make it more complete, accurate, or timely.

WAIVER OF LIABILITY: I hereby release the requester, HRP and UH, and their respective representatives, from all liability, to the fullest extent permitted by the law, for any and all acts performed under this authorization, specifically including the provision of information, documents, or records pursuant to this request.

RELEASE AND WAIVER OF ALL CLAIMS: I specifically waive any claim for damages of any kind against HRP and UH, for acts performed pursuant to this authorization, to the fullest extent permitted by the law, including but not limited to claims of interference with contract, invasion of privacy, defamation, slander, discrimination, denial of employment, admission, licensure, or credentials, or negligence of any kind in the communication of such information to the requester or its representatives.

HOLD HARMLESS AND INDEMNIFICATION: I hereby agree to hold HRP and UH, and their representatives harmless from any and all claims made against it by me, the requester, or any other person or entity as a result of the release of information, documents, or records pursuant to this authorization. Specifically included in "hold harmless and indemnification" within this paragraph are any claims arising from denial of employment, admission, or credentials to me by the requester or its representatives. I further specifically agree to indemnify HRP and UH, and their representatives for any and all legal fees, costs, or any other expenses incurred in defending any claim arising from the release of information, records, or documents sought by this request or provided pursuant to this authorization.

Signature of Authorizing Physician	Date	Print Legal Name of Authorizing Physician

Doc. Date: _____ # Page(s): _____

Notary Name: _____

_____ Judicial Circuit

Doc. Description: *Consent of Information & Release of Liability*

_____
Notary Signature Date

N O T A R Y C E R T I F I C A T I O N

(seal)

On this ____ day of _____, 20___, before me personally appeared _____, to me personally known, who, being by me duly sworn or affirmed, did say that such person executed the foregoing instrument as the free act and deed of such person, and if applicable in the capacity shown, having been duly authorized to execute such instrument in such capacity.

_____

Print Name: _____ (seal)
Notary Public, State of Hawaii.
My commission expires: _____

Your signature must be acknowledged before a Notary Public or other duly authorized officer.
Notary and fee payment not required for some employment salary verifications.

Revised 10/5/2016