Consent to Release of Information and Liability

REQUESTS AND RESPONSES: HRP must receive the verification request directly from the requesting institution or receive the institution's original request forwarded by the physician. Responses will be sent only to the requesting institution. No copy of the response will be provided to the physician.

Trainee Full Name: _____ Other Name(s) Used: _____

HRP Training Program: _____ Dates Attended: _____

Trainee Phone: _____ Trainee email: _____

Institution to receive verification *(one per form/fee)*: _____

Requested method of submission: _____ Address *(email, fax or website)*: _____

This HRP Consent Form requires a *nonrefundable* fee of $50 paid in full to HRP *before* training information is released, ***UNLESS*** one of the following applies, in which case the processing fee is waived *(check any that apply)*:

☐ Trainee is an active resident or fellow, ***currently*** employed by HRP.

☐ This information is being ***requested by an institution located within the State of Hawaii.***

Verification Fee: *A nonrefundable $50 fee will be assessed based on type of verification requested.*

- Payment may be made via check or Money order mailed to: **HAWAII RESIDENCY PROGRAMS, INC.,**
  Attn: Verifications,
  1356 Lusitana, St, Suite 507, Honolulu, HI 96813
- Payments may also be made via Credit Card Processing; a 3% convenience fee is assessed for all credit card payments. Link available after receipt of an executed consent form.
- Payment must be received prior to processing request.

PURPOSE: I am providing this Consent to Release of Information and Release of Liability ("Consent") in order to facilitate my application for employment with admission into, licensure by, or credentialing by, the Requester.
DEFINITIONS: As used in this form, "Requester" is the person or entity seeking information concerning me (as identified above), and includes all of the Requester's employees, agents, and authorized representatives so designated in writing. As used in this form, "HRP" is Hawaii Residency Programs, Inc. (hereafter "HRP") and its Executive Director, administrative personnel, and other employees and agents. As used in this form, "UH" is the University of Hawaii and its Program Director, faculty, administrative personnel, and other employees and agents. As used in this form, "Subject Information" is any and all documents, records and other information and opinions relating to me, including, but not limited to, my performance, competence, character, behavior, and competence and qualifications (such as to practice medicine or to obtain or hold employment, clinical privileges, or professional credentials).
CONSENT AND AUTHORIZATION: I hereby consent and authorize HRP and UH to provide the Requester with any and all Subject Information, (a) regardless of whether HRP or UH came into possession of the Subject Information prior to my employment, during my employment, or after my employment with HRP; (b) regardless of whether the Subject Information is communicated verbally, in written form (hard copy, electronic form, etc.) or otherwise; (c) in HRP's and UH's sole exercise of discretion as to what Subject Information is appropriately responsive to any request; (d) regardless of whether the provision of Subject Information is based on the Requester's pending request, future request, or otherwise; and (e) as HRP and/or UH, in its sole discretion, deems appropriate for purposes of supplementing any Subject Information previously provided (such as where the Subject Information previously provided is no longer complete or accurate or needs to be amended to be made more complete and accurate).
RELEASE AND WAIVER OF LIABILITY: I hereby release the Requester, HRP, and UH from all liability to the fullest extent permitted by the law, for any and all acts performed under this Consent, specifically including the provision of Subject Information. I specifically waive any claim for damages of any kind against HRP and UH, for acts performed pursuant to this Consent, 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 indemnify and hold harmless HRP and UH from any and all claims made by any person or entity (including, but not limited to me and the Requester) as a result of the release of Subject information pursuant to this Consent. As used herein, "claims" includes, but are not limited to, claims arising from the Requester's denial of employment, admission, or credentials. This duty to indemnify includes, but is not limited to, any and all judgments, settlements, legal fees, costs, and any other expenses incurred in defending any claim arising from the release of Subject Information pursuant to this Consent.

Hand-drawn signature of Authorizing Physician: *Signature must be unique (hand-drawn), not in a digital font selection.*

_____ _____

Trainee Signature *Date*

Email completed documents to: verifications@hawaiiresidency.org *Consent is valid for 365 days after signing.*