ATTACHMENT C

AUTHORIZATION FOR RELEASE
OF PROTECTED HEALTH INFORMATION

I hereby authorize_____[facility performing health assessment and/or practitioner overseeing treatment or treatment program] (the "Facility") to provide all information, both written and oral, relevant to an assessment of my health status and my ability to safely practice, to Virtua (the "Hospital") and its Medical Executive Committee or Health Team. The information to be released includes, but is not limited to, answers to the questions on the attached Health Status Assessment Form, along with the following:

(a) the nature of my condition;

(b) whether I am participating in a rehabilitation program or treatment plan;

(c) whether I am in compliance with all of the terms of the program or plan;

(d) to what extent my behavior and/or conduct needs to be monitored;

(e) whether I am rehabilitated or have completed treatment;

(f) whether, if applicable, an after-care program has been recommended for me and, if so, a description of the after-care program; and

(g) whether I am capable of resuming medical practice and providing continuous, competent care to patients.

I understand that the purpose of this Authorization is to allow the Hospital to obtain information that is relevant to my qualifications for medical staff appointment and clinical privileges, including, but not limited to, my ability to care for patients safely and competently and to relate cooperatively with others in the Hospital.

I understand that the willingness of the Facility to conduct this assessment or provide treatment does not depend on my signing this Authorization.

I understand that my health information is protected by federal law and that, by signing this Authorization, the information will be disclosed to the parties hereby authorized to receive it and could be disclosed to other parties. I also understand that the information being disclosed is protected by state peer review laws and that the Facility, the Hospital, and others involved in the peer review process are required to maintain the confidentiality of peer review information pursuant to those state laws.

I understand that I may revoke this Authorization at any time, in writing, except to the extent that the Facility has already relied upon it in making a disclosure to the Hospital. My written revocation will become effective when the Facility has knowledge of it.

This Authorization expires when my medical staff appointment and clinical privileges at the Hospital end. Once this Authorization has expired, the Facility may no longer use or disclose my health information for the purpose listed in this Authorization, unless I sign a new Authorization form.

Date	Signature of Physician