

ATTACHMENT B
CONSENT FOR DISCLOSURE OF INFORMATION
AND
RELEASE FROM LIABILITY

I hereby authorize Virtua (the "Hospital") to provide _____ [facility performing health assessment] (the "Facility") all information, both written and oral, relevant to an evaluation of my health status.

I understand that the purpose of this Authorization and Release is to allow the Facility to conduct a full and complete evaluation of my health status so that the Hospital can determine if I am able to care for patients safely and competently.

I also understand that the information being disclosed is protected by the New Jersey peer review law and that the Hospital, the Facility, and others involved in the peer review process are required to maintain the confidentiality of peer review information, pursuant to that state law.

I release from any and all liability, and agree not to sue, the Hospital, or any of its officers, directors, employees or any physician on the Hospital's Medical Staffs, or any authorized representative of the Hospital, for any matter arising out of the release of information by the Hospital to the Facility.

I also release from any and all liability, and agree not to sue, the Facility, or any of its officers, directors, employees or authorized representatives, for any matter arising out of the Facility's provision of an evaluation of my health status to the Hospital.

Date

Signature of Physician