



Parkland

**RECORDS AND INFORMATION AUTHORIZATION RELEASE
AND
AGREEMENT TO REPORT HEALTH CHANGES, CLAIMS, AND LICENSE MATTERS**

I authorize Parkland Health & Hospital System to communicate with any medical schools, boards, agencies, hospitals, physicians, law enforcement agencies, government agencies, or other organizations and individuals necessary to verify the information contained in my application. I further release Parkland Health & Hospital System, its directors, trustees, officers, agents, employees and members of the house/medical staff from any liability with regard to any information obtained in connection with my application.

I authorize Parkland Health & Hospital System to furnish, upon request, information to other hospitals, medical associations, and other organizations and individuals concerning information in my application, and my performance in the program, including without limitation, competence, ethics, character, health and other information. I release from liability Parkland Health & Hospital System, its directors, trustees, officers, agents, employees and members of the house/medical staff for furnishing such information to other hospitals, medical associations and other organizations and individuals.

I also authorize and request the Medical Director or his designee of the House Staff & Graduate Medical Education Office at Parkland Health & Hospital System to receive my application for an institutional permit, review the permit for completeness and forward the permit to the Texas State Board of Medical Examiners.

I agree to immediately report to the Medical Director or his designee, any change in my physical or mental ability to practice medicine. As well as of the filing of any claim, suit or other proceedings against me alleging professional negligence and any proceeding or inquiry concerning my license to practice medicine.

I attest that the information contained in this application is true, correct and complete.

Signature

Date

Print Name