WORLD SERVICES
Translation and Interpreting Services

Consent for release of Information release of Liability

AUTHORIZATION

I hereby affirm and attest that all statements, answers, and information contained in this application are true to the best of my knowledge, information, and belief. I understand that falsification, misrepresentation, or omission of any fact(s) requested will be sufficient cause for denial of this application and/or subsequent termination of any participating privileges granted upon the basis of this application.

I hereby give permission to World Services LLC, its affiliates and the employees, agents and representatives thereof to obtain information about the operation of this facility. I consent to the release of photocopies/duplication of any of the foregoing, or verbal statements, by hospital administrators, chiefs of clinical departments of hospitals, insurance companies or regulatory agencies that this facility has either conducted business or is associated/affiliated with. Such information may be released to the above named entity and its affiliates or to representatives of such entity and its affiliates.

I hereby release from liability and agree to hold harmless all employees, agents and representative of the above named entity and it affiliates for their acts performed and statements made in connection with obtaining, reviewing and evaluating the credentials and qualifications of this facility. I further acknowledge my cooperation by consenting to the production of such information about services rendered to their clients. The determination of whether the facility is qualified to serve as a provider of services is the reason such information is needed for review and evaluation by the above-named organization and their representatives.

RELEASE OF LIABILITY

I understand of my right to review information obtained by World Services LLC from any outside primary sources to evaluate my credentialing application. I further agree that a photocopy of this document will serve as a duplicate original.

____
Print Name of Authorized Representative

____
Signature of Authorized Representative

____
Title of Authorized Representative

____
Signature Date

ADMINISTRATIVE CONTACT INFORMATION

Name of Provider Representative for administrative purposes: ____

Telephone Number: ______________________ Fax Number: ______________________ Email Address: __________________________

Signature stamps are not accepted