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SYSTEM: Hospital Sisters Health System	**MANUAL(S): Executive Manual**
TITLE: Information Sharing Policy	**ORIGINATING DEPARTMENT: Quality and Physician Relations**
EFFECTIVE DATE: May 17, 2019	**REVISION DATE(S):**
SUPERCEDES: New	

* As required by CMS Regulation §482.12 A-0043 Conditions of Participation: Governing Body, the following hospitals and entities are included as HSHS entities: **ILLINOIS**: (1) HSHS St. John's Hospital – Springfield (2) HSHS St. Mary's Hospital – Decatur, (3) HSHS St. Francis Hospital – Litchfield, (4) HSHS Good Shepherd Hospital – Shelbyville, (5) HSHS St. Anthony's Memorial Hospital – Effingham, (6) HSHS St. Joseph's Hospital – Highland, (7) HSHS St. Joseph's Hospital – Breese, (8) HSHS St. Elizabeth's Hospital – O'Fallon, (9) HSHS Holy Family Hospital – Greenville, (10) HSHS Medical Group, Prairie Cardiovascular Consultants **WISCONSIN**: (1) HSHS St. Vincent Hospital – Green Bay, (2) HSHS St. Mary's Hospital Medical Center – Green Bay, (3) HSHS St. Clare Memorial Hospital – Oconto Falls, (4) HSHS St. Nicholas Hospital - Sheboygan, (5) HSHS Sacred Heart Hospital – Eau Claire, (6) HSHS St. Joseph's Hospital – Chippewa Falls, (7) LaSante Wisconsin, Inc., d/b/a/ HME Home Medical, (8) Libertas Treatment Center – Green Bay and Marinette (9) Door County Medical Corporation (10) Pain Centers of Wisconsin – Green Bay, LLC (11) Pain Centers of Wisconsin – Oconto Falls, LLC (12) Prevea Health Services, Inc. (13) Prevea Clinic, Inc. (14) Unity Limited Partnership (15) HSHS Wisconsin Medical Group, Inc. (16) OakLeaf Clinics, Inc. (17) Hospital Sisters Healthcare-West, Inc. (18) Green Bay Oncology, Inc.

I. POLICY:

All Applicants and Practitioners, as defined herein, shall be required to execute an authorization and release document in a form that is the same as or substantially similar to the "Authorization and Release from Liability Form" attached to this policy, and incorporated herein, as **Exhibit A**. This policy shall therefore apply to all Participants, Applicants and Practitioners.

II. PURPOSE:

Each Participant has established Peer Review Processes in order to review and evaluate: (1) the quality and appropriateness of patient care provided by Practitioners; and (2) the qualifications of Applicants and Practitioners to obtain and/or maintain medical staff membership, clinical privileges, and/or participation with a Participant. The purpose of this Professional Information Sharing Policy is to facilitate the appropriate sharing of information, including Peer Review Information, by and among the Peer Review Committees of the Participants and (where applicable) their respective medical staffs, in order to foster each Participant's Peer Review Processes, and in doing so, to reduce morbidity and mortality, and improve the quality of patient care. This policy shall also ensure that information is shared in a manner that preserves the confidential and privileged nature of the information, as applicable, to the fullest extent permitted by State and Federal law.

III. SCOPE:

This policy is applicable to all HSHS hospitals*, Physicians' Organizations, and operating entities including their employees, agents and medical staff, as well as employed physicians of an HSHS Medical Group.

IV. DEFINITIONS:

For purposes of this policy, the following definitions apply:

A. Applicant refers to any independent licensed practitioner who applies for membership, clinical privileges and/or participation (as applicable) with a Participant.
B. Appropriate Notice refers to the legitimate notice indicating the availability of Peer Review Information, which is provided pursuant to this policy, and which meets the requirements set forth in Section V.C.2 of this policy.
C. Appropriate Request refers to a legitimate request for Peer Review Information, which is made pursuant to this policy, and which meets the requirements set forth in Section V.B.2 of this policy.

D. Authorized Representative refers to an administrator, committee member or other individual who has been appropriately authorized by a Peer Review Committee to request, communicate or share information on behalf of a Participant and/or Peer Review Committee of a Participant.

E. Final Adverse Action refers to any final action that is taken, or agreed to, by the governing body of a Participant with respect to an Applicant or Practitioner after having provided the Applicant or Practitioner with all due process rights to which he or she may be entitled. A final action is adverse when the action negatively affects or otherwise restricts an Applicant or Practitioner from receiving, maintaining, and/or exercising medical staff membership, clinical privileges or participation (as applicable) with a Participant. Final Adverse Actions may include, but are not necessarily limited to, the following:
   - Denial of an application or reapplication for medical staff membership, clinical privileges and/or participation with a Participant;
   - Revocation, suspension, reduction or termination of medical staff membership, clinical privileges and/or participation with a Participant;
   - Proctoring, consultation, concurrent monitoring or any other limitation placed upon medical staff membership, clinical privileges and/or participation with a Participant that is intended as a restriction of medical staff membership, clinical privileges and/or participation with a Participant;
   - Any agreement by an Applicant or Practitioner to withdraw an application for medical staff membership, clinical privileges and/or participation with a Participant in order to avoid a formal investigation or adverse action; or
   - Any agreement by a Practitioner to refrain from exercising, in full or in part, temporarily or permanently, medical staff membership, clinical privileges and/or participation with a Participant in order to avoid a formal investigation or an adverse action.

F. Peer Review Committee refers to any committee organized by a Participant, or the medical staff of a Participant, which functions, in full or in part, to conduct internal quality control or medical study for the purpose of reducing morbidity or mortality, and/or for improving patient care, or that fulfills another legitimate peer review function permitted by applicable law. Credentialing committees, medical executive committees, utilization review committees, focused professional practice evaluation committees, ongoing professional practice evaluation committees, practitioner impairment committees, quality review and improvement committees, and other quality assurance and/or patient safety-related committees are routinely organized for this purpose.

G. Peer Review Information refers to and includes all information, interviews, reports, statements, memoranda, recommendations, letters of reference or other third party confidential assessments of a health care practitioner's professional competence, or other data, communications or determinations generated, requested, used or made as part of a legitimate Peer Review Process. Peer Review Information is strictly confidential and privileged, and shall only be used for medical research, the evaluation and improvement of quality of care, and/or for granting, limiting or revoking medical staff privileges or agreements for services.

H. Peer Review Process refers to and includes any formal process whereby a Peer Review Committee of a Participant, or a Peer Review Committee of the medical staff of a Participant (as applicable), conducts internal quality control or medical study for the purpose of reducing morbidity or mortality, and/or for improving patient care. Peer Review Processes routinely include credentialing processes, utilization review, focused professional practice evaluation, ongoing professional practice evaluation, corrective action processes, and other quality review, improvement and/or assurance processes utilized to evaluate the competency and/or professional conduct of Applicants and Practitioners. A Peer Review Process may, or may not, result in a Final Adverse Action.

I. Practitioner refers to any independent licensed practitioner that has received and/or maintains medical staff membership, clinical privileges, employment, and/or participation with a Participant.

V. POLICY STATEMENTS:

A. Participants should share Final Adverse Actions.
Participants are encouraged to provide prompt notice to other pertinent Participants whenever Final Adverse Action is taken with respect to an Applicant or Practitioner.

B. Peer Review Committees may elect to share Peer Review Information.
Peer Review Committees may elect, upon Appropriate Request, to share Peer Review Information with other Peer Review Committees.

C. Peer Review Committees may elect to share the availability of Peer Review Information. Peer Review Committees may elect to notify other Peer Review Committees of the availability of Peer Review Information. Peer Review Committees receiving such notification may choose to make an Appropriate Request for Peer Review Information.

D. Peer Review Information sharing should preserve all applicable legal protections.
The rights, obligations, policies and procedures set forth in this Professional Information Sharing Policy are intended to facilitate the appropriate exchange of information, including Peer Review Information. This policy is in no fashion intended to restrict any rights afforded by State and Federal Law, or appropriately authorized by an Applicant or Practitioner, with respect to the use or sharing of information, including Peer Review Information, or any other rights. This policy, and the attached authorizations, are intended to appropriately supplement all such rights afforded by State and Federal law.

VI. PROCEDURES:

A. Procedure for sharing Final Adverse Actions.
When a Participant takes Final Adverse Action with respect to an Applicant or Practitioner, the Participant, by an Authorized Representative, should promptly provide notice of the Final Adverse Action to other Participants where the Applicant or Practitioner is known, or suspected, to have or maintain medical staff membership, clinical privileges and/or participation. A Participant may choose to utilize the attached **Form 1** to provide such notice.
In the event a Participant receives notice of Final Adverse Action, the Participant (by a Peer Review Committee) may elect to request additional information as set forth in the following subsection B.

B. Procedure for sharing Peer Review Information upon Appropriate Request.
A Peer Review Committee may elect, upon Appropriate Request, to share Peer Review Information with a Peer Review Committee of another Participant, or a Peer Review Committee of another Participant's medical staff.

1. Upon receiving a request to share Peer Review Information, the Peer Review Committee should first ensure that the request is an Appropriate Request.
2. A request for Peer Review Information is an Appropriate Request when:
    a. The request is made by an Authorized Representative of a Peer Review Committee;
    b. The request is made in writing and is in a form reasonably consistent with the attached **Form 2**, unless there is concern regarding patient safety or other circumstances which are determined to require a more urgent request, in which case a verbal request may be made;
    c. The request should, when reasonably possible, include a copy of the " Authorization and Release from Liability Form" (attached to this policy as **Exhibit A**) that has been signed and dated by the subject Applicant or Practitioner. Minimally, the Participants must verify that a current/valid "Consent, Authorization to Disclose Information and Release from Liability" has been executed by the subject Practitioner prior to any request or response; and
    d. **When the request is made by a Participant in the State of Illinois**, the request must affirm, and must include or be accompanied by a statement, that the request is made as part of a legitimate and ongoing Peer Review Process.
3. After determining that a request for Peer Review Information is an Appropriate Request, the Peer Review Committee (by way of the Peer Review Committee or by way of an Authorized Representative) may choose to share, or not share, responsive Peer Review Information.
4. In the event the responding Peer Review Committee or Authorized Representative ("Responding Party") chooses to share Peer Review Information, and subject to the following Paragraph 5, the Responding Party shall:
    a. Determine the nature and extent of any Peer Review Information to be provided;
    b. Redact, as deemed appropriate, any witness names or other sensitive information;
    c. Redact, as deemed necessary or appropriate, any protected health information contained in the Peer Review Information;
    d. In the event drug or alcohol treatment records (subject to 42 C.F.R. Part 2) will be produced, require the requesting Peer Review Committee to first provide (prior to any response) a fully executed copy of the Authorization attached hereto as **Exhibit B**;
    e. Deliver the Peer Review Information to the requesting Peer Review Committee by hand-delivery, certified mail or secured/encrypted electronic communication; and

f. Utilize the attached **Form 3** to provide transmittal communication to the Peer Review Committee receiving the Peer Review Information.

5. The Responding Party should share Peer Review Information in written form whenever reasonably possible. In the event, however, there is concern regarding patient safety and/or other circumstances which are determined to require a more urgent response, a Responding Party may verbally provide Peer Review Information.
6. All requests for Peer Review Information pursuant to this policy, and all proposed responses to such requests, when reasonably possible, should be reviewed and approved by the applicable Participant's Legal Department prior to the request being made, or prior to the Peer Review Information being shared, as applicable.

C. Procedure for providing notice of the availability of Peer Review Information.

A Peer Review Committee of any Participant may elect to notify a Peer Review Committee of another Participant, or a Peer Review Committee of another Participant's medical staff, regarding the availability of Peer Review Information. Participants in Wisconsin may, in addition to such notice, share Peer Review Information with other Participants in Wisconsin as set forth below.

1. A Peer Review Committee (the "Notifying Party") may elect to serve notice of Peer Review Information under the following circumstances:
   a. The Notifying Party has knowledge of Peer Review Information. **When the request is made by a Participant in the State of Illinois**, the content of which would require the Applicant or Practitioner (as applicable) to timely supplement his or her Business Data Gathering Form and/or Application; all Participants and their Peer Review Committees have, by executing the Peer Review Sharing Agreement, acknowledged their standing request, pursuant to their respective ongoing Peer Review Processes, to timely receive notice of any required supplementation to the Business Data Gathering Form and/or Application; and all Applicants and Practitioners have authorized, by executing the "Consent, Authorization to Disclose Information and Release from Liability," the Notifying Party to provide such supplemental information, which may include (but is not limited to) the following:
      - Loss or restriction of professional license;
      - Loss of Board Certification;
      - Failure to pass a Certifying Exam;
      - Loss or restriction of federal Drug Enforcement Agency number and/or state-controlled substance license;
      - Any disciplinary action or proceeding initiated or pending with respect to clinical privileges at any hospital or ambulatory surgery center;
      - Any reprimand, censure, exclusion, suspension and/or disqualification, or voluntary withdrawal to avoid investigation, from Medicare, Medicaid, CHAMPUS, and/or any other governmental health-related programs;
      - Professional liability actions, judgments or settlements;
      - Any denial or relinquishment of professional liability insurance, or any cancellation, non-renewal or reduction in coverage;
      - Any conviction of a criminal offense (other than a minor traffic offense) or civil, criminal or administrative action or investigation resulting from allegations of sexual misconduct, child abuse, domestic violence or elder abuse; or
      - Any medical condition or other impairment that impairs and/or limits the ability to practice medicine with reasonable skill and safety; or
   b. The Notifying Party has knowledge of Peer Review Information that may assist another Peer Review Committee, through a legitimate Peer Review Process, to ensure patient safety, reduce morbidity or mortality, and/or improve patient care.
2. If a Notifying Party elects to provide notice of Peer Review Information, it must provide the notice by way of Appropriate Notice, which is defined as follows:
   a. The notice is only made following confirmation that the subject Practitioner has executed a valid "Authorization and Release from Liability Form;"
   b. The notice is made in writing whenever reasonably possible and is in a form reasonably consistent with **Form 4**, unless the Notifying Party determines that there is concern regarding patient safety and/or other

circumstances which are determined to require a more urgent response, in which case verbal notice may be provided;

c. The notice is provided by an Authorized Representative of the Notifying Party;
d. The notice is provided to an Authorized Representative of the Peer Review Committee receiving the notice;
e. **When the notice is made from or to a Participant in the State of Illinois**, the notice does not contain any substantive Peer Review Information; the notice (whether written or verbal) states **only** that Peer Review Information is available and may be requested; and
f. **When the notice is made from and to a Participant in the State of Wisconsin**, the notice may or may not contain, in the discretion of the Notifying Party, substantive Peer Review Information. In the event the Notifying Party elects to produce Peer Review Information absent an Authorized Request the Notifying Party must ensure that the Peer Review Information is produced to the appropriate Peer Review Committee(s) and/or Authorized Representative(s) in the same manner as set forth above in Section V(B)(4).

3. Appropriate Notice, when written, should be delivered by hand-delivery, certified mail or secured/encrypted electronic communication.
4. All proposed notices, when reasonably possible, should be reviewed and approved by the applicable Participant's Legal Department prior to being provided to the Peer Review Committee receiving the notice.
5. Providing Appropriate Notice does not obligate the Notifying Party to ultimately share Peer Review Information; any request for Peer Review Information made in response to the Appropriate Notice should be considered and addressed by the Notifying Party as set forth in Section V.B, above.
6. The right to provide notice of Peer Review Information, as set forth in this Section V.C, is in addition to any and all rights already vested in Participants and Peer Review Committees to provide similar notice in response to lawful credentialing inquiries.

VII. CONFIDENTIALITY AND PRIVILEGE

All Participants and Peer Review Committees shall strictly maintain the confidential and privileged nature of any Peer Review Information that is shared (whether disclosed or received) pursuant to this policy. Peer Review Information received pursuant to this policy shall only be utilized as part of an ongoing Peer Review Process and shall be stored in a confidential and secure manner. Peer Review Information shall never be disclosed outside of a Peer Review Process unless strictly required by law, nor shall Peer Review Information be used for any purpose other than a legitimate peer review function. Any and all questions regarding the use of Peer Review Information should be directed to the applicable Participant's Legal Department prior to the intended use in question. Once a Peer Review Committee has exhausted its appropriate use of Peer Review Information received pursuant to this policy, the Peer Review Committee shall destroy and/or delete the Peer Review Information, as applicable (consistent with any internal document retention policies applicable to peer review information).

Originator: Marc Shelton, M.D.
Chief Physician Executive

Accountable Leader: Marc Shelton, M.D.
Chief Physician Executive

Administrative Approval: Mary Starmann-Harrison
President and CEO

EXHIBIT A

AUTHORIZATION AND RELEASE FROM LIABILITY FORM

(Please read carefully before signing)

I understand that Hospital Sisters Health System ("**HSHS**") is a health care system comprised of multiple hospitals, clinics, and other health care facilities and organizations located in the States of Illinois and Wisconsin (collectively "**HSHS Entities**"). In consideration of my application for appointment, clinical privileges and/or permission to practice (collectively, the "**Privileges**") at one or more HSHS Entities, I hereby acknowledge, agree to, and fully accept all terms and conditions set forth in this Authorization and Release from Liability Form, both (i) during the processing and consideration of my application, whether or not I am granted Privileges at an HSHS Entity, and (ii) for the duration of such appointment, privileges or permission to practice as I may be granted. I further acknowledge and agree that these terms and conditions shall be in addition to all other terms and conditions, including but not limited to provisions regarding authorization and release, that may be set forth in the form of application for Privileges, the Health Care Professional Credentialing and Business Data Gathering Form (if I am applying for Privileges at an HSHS Entity in the State of Illinois), and all applicable Bylaws, Rules and Regulations, and Policies of HSHS, HSHS Entities, and other HSHS Affiliates (as defined below).

Authorization to Request and Obtain Information

As an applicant for Privileges at one or more HSHS Entities, I hereby authorize HSHS, each HSHS Entity, each HSHS Medical Staff, any Credentialing Verification Organization functioning on behalf of one or more HSHS Entities, and each of their respective directors, officers, employees, agents, medical staff members, and other authorized representatives, (collectively referred to herein as **"HSHS Affiliates"**) to (i) conduct a criminal history background check, (ii) receive information from my professional liability insurance carrier(s), (iii) consult with and receive records and information from (a) members of the medical staff, healthcare workers or their representatives at other hospitals or institutions with which I have been associated, including but not limited to other HSHS Affiliates, and (b) licensing agencies, medical schools, medical associations, regulatory databanks, medical clinics or physicians and other healthcare workers with whom I have been affiliated, who may have information bearing on my professional competence, character and ethical qualifications, all of whom are collectively referred to herein as **"Responding Parties."** I specifically authorize said HSHS Affiliates and Responding Parties to release such records and information to the HSHS Affiliate(s) making the request. Additionally, I am willing to make myself available for interview(s) with applicable HSHS Affiliates in connection with this application. I hereby further consent to the inspection by the HSHS Affiliates of all records and documents, including medical records at other hospitals and information from my professional liability insurance carrier(s) regarding the status of claims, settlements and verdicts, that may be material to an evaluation of my professional qualifications, capability and competence to carry out the Privileges requested at the HSHS Entity, as well as my moral and ethical qualifications for such Privileges (collectively, the "**Qualifications**").

Authorization to Release Information

I hereby authorize and consent to the release of information by each HSHS Affiliate to other hospitals, medical associations, licensing agencies, clinics, physicians, or other employers with which or whom I have been affiliated as a member, student, employee or partner, or with which or whom I have applied for affiliation, privileges, membership, admission, or employment, upon their request regarding any information each HSHS Affiliate may have concerning me.

Information Sharing

I acknowledge and agree that I have received and/or have been provided access to, and I have read, the HSHS Professional Information Sharing Policy. I fully understand, I consent to, and I agree to comply with and be bound by the provisions contained in the HSHS Professional Information Sharing Policy. Accordingly, and in addition to the foregoing, I authorize each HSHS Affiliate to request and to release information bearing or potentially bearing on my Qualifications to/from any and all other HSHS Affiliates where I: (i) have Privileges, (ii) have applied or subsequently do apply for Privileges, or (iii) am employed or am seeking employment, in accordance with the HSHS Professional Information Sharing Policy, as amended from time to time. I fully recognize and agree that such documentation and information may contain confidential peer review information, and I authorize and consent to the release of this information to the fullest extent contemplated by this Policy. I further acknowledge, consistent with the HSHS Professional Information

Sharing Policy, that it is my on-going responsibility, throughout the application process and the duration of any Privileges or my employment at any HSHS Entity, to notify each HSHS Entity at which I currently have, or have applied for Privileges, of any concerns, issues, updates, or other matters related to, or potentially related to, my Qualifications. In partial fulfillment of this responsibility, and for the purpose of ongoing patient quality, peer and professional review, I hereby direct any HSHS Entity with knowledge of any concern, issue, update or other matter that is related to, or potentially related to, my Qualifications to, on my behalf, notify the appropriate representatives of other HSHS Entities at which I currently have or have applied for Privileges, or where I have or have applied for employment.

Release from Liability

I hereby **RELEASE, WAIVE, INDEMNIFY, HOLD HARMLESS and FOREVER DISCHARGE** each HSHS Affiliate from any and all past, present or future claims, demands, actions or causes of action, rights, damages, costs, expenses, fees, and compensation of any nature whatsoever, whether based on a tort, contract or other theory of recovery related either directly or indirectly to the release or disclosure documentation and information in accordance with this Authorization and Release from Liability, including but certainly not limited to the sharing of peer review information contemplated by the HSHS Professional Information Sharing, which I acknowledge I have expressly authorized herein. I further hereby fully release from any and all liability all any individuals, organizations, or other Responding Parties who may provide the information or documentation to any HSHS Affiliate(s) pursuant to this Authorization and Release from Liability. I further acknowledge and agree that nothing in this Authorization and Release from Liability should be construed as a waiver of any of the rights, protections of confidentiality, and privileges afforded to the HSHS Affiliates by State or Federal law or regulation.

Burden of Providing/Supplementing Information

I agree and acknowledge that it is my obligation to provide to any HSHS Affiliate at which I seek to obtain or maintain Privileges adequate, accurate and complete information to process my application, and that my application will not be processed until it is deemed complete by the applicable HSHS Affiliate. I further agree and acknowledge that it is my obligation to promptly report in writing to the administrators of all HSHS Affiliates at which I hold Privileges, during the term of my appointment, if there are any changes in any of the information I have provided in this application, including but not limited to information regarding licensure, DEA status, insurance, malpractice claims, NPDB/HIPDB reports, medical staff discipline, criminal convictions, and other updated information as may be required by the applicable Business Data Gathering Form or application. I acknowledge and agree that my failure to do so may be the basis to immediately cease processing of my application or automatic relinquishment of privileges or summary dismissal from the Hospital's medical staff(s). Additionally, consistent with the HSHS Professional Information Sharing Policy, and in partial fulfillment of my affirmative and ongoing obligation to supplement my Business Data Gathering Form and/or application at each HSHS Affiliate where submitted, I hereby authorize, consent to, request and direct each HSHS Affiliate to notify other HSHS Affiliates of any such information to the fullest extent set forth in the HSHS Professional Information Sharing Policy.

Compliance with Medical Staff Bylaws and Rules & Regulations

For each HSHS Affiliate at which I hold or seek Privileges, and in addition to the HSHS Professional Information Sharing Policy, I have had an opportunity to review a copy of the Medical Staff Bylaws, Rules and Regulations, and Policies as are in force at the time of my application. I agree to be bound by and comply with such Medical Staff Bylaws, Rules and Regulations, and Policies as they may be amended, in all matters related to the medical staff appointment and membership, without regard to whether or not appointment to the medical staff and/or clinical privileges are granted.

Placement of Information on Website

I authorize HSHS Affiliates, in their sole discretion, to post information about me and/or my affiliation with the HSHS Affiliate(s) on HSHS affiliated website(s). I agree to review the information about me posted on such websites, and to notify the applicable HSHS Affiliate(s) in writing of any inaccuracy. I acknowledge and agree that the public will have access to this information.

Use of Copy; Electronic Signature

I agree that a photocopy, facsimile, scanned or other electronic copy of this document with my signature may be accepted by an organization or individual from which the above referenced information is requested, with the same authority as the original. I specifically waive any notice obligation on the part of such organizations or individuals to inform me when they provide information to any HSHS Affiliate(s), or any other individual, organization, or other Responding Party based on this consent and release. I further understand that my signature, as provided below, may be provided in handwritten or electronic form. I acknowledge and agree, and I request, that in the event I provide my signature electronically, my electronic signature shall constitute an original signature and shall have the same legal force and effect as a handwritten signature.

Duration of Authorization and Release
The foregoing shall remain in effect as a full authorization unless and until revoked in writing by the undersigned.

Accuracy of information
All information provided by me in my application is true and complete to the best of my knowledge and belief. I understand and agree that any material misstatement in or omission from the application may constitute grounds to immediately cease processing of my application or automatic relinquishment of privileges or summary dismissal from the applicable HSHS Affiliate's medical staff (s). I understand and acknowledge that each HSHS Affiliate shall be solely responsible for its decision(s) concerning medical staff appointment or reappointment and the granting of clinical privileges. I further understand and acknowledge that CVO shall have no responsibility or liability with respect to medical staff appointment or reappointment decisions or the granting of clinical privileges by the applicable HSHS Affiliate(s).

_____ _____
Signature (stamped Signatures are Unacceptable) Date

_____
Name Printed

EXHIBIT B

Authorization for the Release of Treatment Information Subject to Federal Law

I hereby authorize _____ *[name of entity that possesses drug/alcohol treatment information]* to release to _____ *[name of entity to receive drug/alcohol treatment information]* all the information it possesses relevant to an assessment of my health status.

I understand that the purpose of this authorization is to allow for a review of my qualifications and my ability to safely and competently provide health care services to patients.

I understand that the information being disclosed is protected by federal law (42 C.F.R. Part 2) and State peer review protection laws. I also understand that the entity receiving this information is prohibited by federal law from re-disclosing it to another entity unless I specifically authorize that disclosure.

I understand that I may revoke this authorization at any time, in writing, except to the extent that the entity making the disclosure has already relied upon it. My written revocation will become effective when the entity that has my health information becomes aware of the revocation.

This authorization expires upon the later of the termination, expiration, or resignation of: (1) my Medical Staff appointment and clinical privileges at_____; (2) my employment, partnership, or other association with _____; or (3) any court proceedings related to either (1) or (2). Once this authorization has expired, any facility that possesses my health information may not disclose it unless I sign a new authorization form.

_____ _____

Date Signature of Practitioner

CONFIDENTIAL AND PRIVILEGED PEER REVIEW DOCUMENT*

Form 1: Notice of Final Adverse Action

[INSERT DATE]

[INSERT ADDRESS OF PARTICIPANT
RECEIVING COMMUNICATION]

Dear [AUTHORIZED REPRESENTATIVE]:

I am writing on behalf of [PARTICIPANT] pursuant to the HSHS Professional Information Sharing Policy. The purpose of this communication is to advise you that [PARTICIPANT] recently took a Final Adverse Action with respect to [APPLICANT OR PRACTITIONER].

The effective date of the Final Adverse Action was _____. The nature of the Final Adverse Action was [INSERT ACTION TAKEN – E.G., A DENIAL, RESTRICTION, SUSPENSION, REVOCATION OF MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES, PARTICIPANT, ETC.]

In the event you wish to request additional information, please make an Appropriate Request pursuant to the HSHS Professional Information Sharing Policy.

Sincerely,

_____
[AUTHORIZED REPRESENTATIVE]

***THIS CONFIDENTIAL AND PRIVILEGED DOCUMENT SHOULD BE MAINTAINED IN THE MEDICAL STAFF OFFICE. THIS DOCUMENT SHALL NOT BE PLACED IN ANY PATIENT CHART AND IS NOT INTENDED FOR ANY UNAUTHORIZED USE OUTSIDE OF THE PEER REVIEW PROCESS**

CONFIDENTIAL AND PRIVILEGED PEER REVIEW DOCUMENT*

Form 2: Request for Peer Review Information

[INSERT DATE]

[INSERT ADDRESS OF PARTICIPANT
RECEIVING COMMUNICATION]

Dear [AUTHORIZED REPRESENTATIVE]:

I am writing on behalf of [PEER REVIEW COMMITTEE MAKING REQUEST ("REQUESTING PARTY")] pursuant to the HSHS Professional Information Sharing Policy. The purpose of this communication is to request that [PEER REVIEW COMMITTEE RESPONDING TO REQUEST ("RESPONDING PARTY")] share Peer Review Information pertinent to [APPLICANT OR PARTICIPANT].

[REQUESTING PARTY] is making this request as part of a legitimate and ongoing Peer Review Process, the intent of which is to further the quality of patient care. I have attached to this communication a copy of the "Authorization and Release from Liability Form," which has been signed and dated by [APPLICANT OR PRACTITIONER].

Pursuant to this authorization, [REQUESTING PARTY] requests that [RESPONDING PARTY] provide Peer Review Information, if any exists, that pertains to: [INSERT NATURE OF INFORMATION REQUESTED]. Please direct any such confidential response to my attention.

[REQUESTING PARTY] affirms that it will maintain the strict confidentiality and privileged nature of any information that is shared, and that it will maintain and store this information in a secure manner, as set forth in the HSHS Professional Information Sharing Policy.

Should you have any questions or concerns regarding the nature of this request, please contact me at the number below.

Sincerely,

_____
[AUTHORIZED REPRESENTATIVE]

***THIS CONFIDENTIAL AND PRIVILEGED DOCUMENT (AND ALL ATTACHMENTS) SHOULD BE MAINTAINED IN THE MEDICAL STAFF OFFICE. THIS DOCUMENT SHALL NOT BE PLACED IN ANY PATIENT CHART AND IS NOT INTENDED FOR ANY UNAUTHORIZED USE OUTSIDE OF THE PEER REVIEW PROCESS**

CONFIDENTIAL AND PRIVILEGED PEER REVIEW DOCUMENT*

Form 3: Response to Request for Peer Review Information

[INSERT DATE]

[INSERT ADDRESS OF PARTICIPANT
RECEIVING COMMUNICATION]

Dear [AUTHORIZED REPRESENTATIVE]:

You recently made a request on behalf of [PEER REVIEW COMMITTEE MAKING REQUEST ("REQUESTING PARTY")] for Confidential Peer Review Information pertinent to [APPLICANT OR PRACTITIONER]. You made this request as part of an ongoing peer review process. A copy of your request, including the fully executed "Authorization and Release from Liability Form" you provided, is enclosed.

[PEER REVIEW COMMITTEE RESPONDING TO REQUEST ("RESPONDING PARTY") has considered your request, and pursuant to the HSHS Professional Information Sharing Policy, has elected to provide a response. The following documentation, totaling [NUMBER OF] pages, is enclosed for legitimate peer review use: [INSERT REFERENCE TO DOCUMENTS PROVIDED].

[REQUESTING PARTY] previously confirmed its commitment, which [RESPONDING PARTY] hereby acknowledges, to utilize the enclosed information exclusively for a legitimate peer review purpose, as part of a legitimate and ongoing Peer Review Process. Pursuant to the HSHS Professional Information Sharing Policy, [REQUESTING PARTY] has agreed to honor the strictly confidential and privileged nature of these documents. These documents may not be utilized for any unauthorized or non-peer review purpose. These documents must be destroyed or deleted, as applicable, following use, as set forth in the HSHS Professional Information Sharing Policy.

Should you have any questions or concerns regarding this response, please contact me at the number below.

Sincerely,

_____
[AUTHORIZED REPRESENTATIVE]

***THIS CONFIDENTIAL AND PRIVILEGED DOCUMENT (AND ALL ATTACHMENTS) SHOULD BE MAINTAINED IN THE MEDICAL STAFF OFFICE. THIS DOCUMENT SHALL NOT BE PLACED IN ANY PATIENT CHART AND IS NOT INTENDED FOR ANY UNAUTHORIZED USE OUTSIDE OF THE PEER REVIEW PROCES**

COPIES ARE ONLY VALID ON THE DAY PRINTED-OFFICIAL POLICY RESIDES IN MCN

CONFIDENTIAL AND PRIVILEGED PEER REVIEW DOCUMENT*

Form 4: Notice of Peer Review Information

[INSERT DATE]

[INSERT ADDRESS OF PARTICIPANT
RECEIVING COMMUNICATION]

Dear [AUTHORIZED REPRESENTATIVE]:

I am writing on behalf of [PEER REVIEW COMMITTEE PROVIDING NOTICE] pursuant to the HSHS Professional Information Sharing Policy. The purpose of this communication is to advise you that Peer Review Information is available regarding [APPLICANT OR PRACTITIONER].

[IF APPLICABLE, ADD: [RECEIVING PARTICIPANT OR PEER REVIEW COMMITTEE] has requested, as part of an ongoing Peer Review Process, to receive notice of any required supplementation by [APPLICANT OR PRACTITIONER] to [his/her] Business Data Gathering Form and/or Application. [APPLICANT OR PRACTITIONER], by executing the enclosed, "Authorization and Release from Liability Form," has authorized [PEER REVIEW COMMITTEE PROVIDING NOTICE] to provide such supplemental information."]

In the event you wish to request additional information, please make an Appropriate Request pursuant to the HSHS Professional Information Sharing Policy.

Sincerely,

_____
[AUTHORIZED REPRESENTATIVE]

***THIS CONFIDENTIAL AND PRIVILEGED DOCUMENT (AND ALL ATTACHMENTS) SHOULD BE MAINTAINED IN THE MEDICAL STAFF OFFICE. THIS DOCUMENT SHALL NOT BE PLACED IN ANY PATIENT CHART AND IS NOT INTENDED FOR ANY UNAUTHORIZED USE OUTSIDE OF THE PEER REVIEW PROCESS**