Dear Peer Reviewer Applicant:

Thank you for your interest in the KEPRO Peer Review Program as it signals your commitment to a significant objective – continuing improvement of the quality and utilization of health care services. We fully appreciate the value of your time and earnestly suggest that your participation in the peer review process in today's health care climate is close to an ethical imperative.

KEPRO is a nationally recognized provider of healthcare management solutions in both state and federal government, as well as commercial clients, providing prior authorization, utilization and specialty review, and case and disease management services.

To accomplish our objectives, KEPRO must have sufficient numbers of qualified peer reviewers who must meet the following criteria:

- Are doctors of medicine, osteopathic medicine, dentist, podiatry, or other allied health care practitioner
- Hold an active, unrestricted license or certification to practice medicine or a health profession in a state or territory of the United States
- Physicians must be Board Certified in a specialty recognized by the American Board of Medical Specialties, the Advisory Board of Osteopathic Specialists, the American Dental Association's (ADA) specialty boards or the American Board of General Dentistry (ABGD); or, the American Board of Podiatric Surgery (ABPS) or the American Board of Podiatric Medicine (ABPM).
- Must be located within the U.S. or one of its territories when conducting an internal appeal or external review.

We can then ensure that all quality and utilization determinations completed and follow-up actions taken are the result of true peer review.

KEPRO provides liability coverage for peer reviewer activities and the reviewer's name will remain confidential except in instances where identification is required by law or by specific contract.

We provide compensation for our reviewers based on the type of review or service being requested and/or amount allowed by the individual customer for whom the work is being performed. Compensation of services will be made within 45 days of receipt of the completed report and invoice.

While we cannot guarantee any pre-established volume commitments, your approval as a credentialed peer reviewer will present you with opportunities to work with our organization in both the private and public sector.

**** To become a KEPRO peer reviewer, please download and complete the application packet. Please return it, along with your current curriculum vitae to our secure fax number listed below.****

Please do not email your credentialing/recredentialing applications. Instead, send them through KEPRO's secure fax number: 717-265-7095

Should you have additional questions, please contact our Credentialing Department at (717) 564-8288, extension 7028 or 7090. We look forward to your participation in the peer review process.

KEPRO Medical Affairs Department
Enclosure(s)

INSTRUCTIONS FOR COMPLETING THE PEER REVIEWER APPLICATION AND CREDENTIALING PROCESS

The Keystone Peer Review Organization (KEPRO) and its subsidiary companies contract with various State and Federal government agencies, as well as commercial insurance entities, to perform review. Individual contracts have unique requirements for documentation of reviewer credentials. The questions asked and information sought on the forms that follow are either requirements of those contracts and/or will facilitate our staff in contacting you regarding performance of review services. The KEPRO application packet includes:

1. **Peer Reviewer Application**
   This form collects information about your office, licensure, potential conflicts of interest, and experience. This application also includes questions applicable to Peer Reviewer Small Business Administration (SBA) information, which helps KEPRO comply with Federal Government contracting requirements. Please complete this portion to enable KEPRO comply with contract requirements. **Note:** The SBA section of the application requires your signature. ****All applicants must complete this Application.** **

**** To become a KEPRO peer reviewer, please download and complete the application packet. Please return it, along with your current curriculum vitae to our secure fax number listed below. ****

Please do not email your credentialing/recredentialing applications. Instead, send them through KEPRO's secure fax number: 717-265-7095

2. **Review Agreement**
   This agreement explains the obligations of a peer reviewer and requests each applicant to specify those review types, which he/she agrees to perform**. * * All applicants must complete this Agreement**. **

3. **HIPAA/Confidentiality Agreement**
   This form is to acknowledge the applicant's understanding of confidentiality and disclosure policies. ****All applicants must read this policy, complete this Agreement, and complete the on-line HIPAA/Code of Conduct/Conflict of Interest (COI)/Ethics training. Instructions to follow.** **

4. **Authority to Release Information**
   To meet the requirements of certain contracts, a copy of this form may need to be submitted to the Medical Staff President (or designee) of the facility in which you primarily practice and maintain staff privileges for confirmation of such privileges. ****This Release must be completed by all applicants in order to assure authorized release of confidential credentialing information.** **

****In addition to submitting all components of the KEPRO application packet, you must submit a copy of your current curriculum vitae (preferably in an electronic document format).** **

Peer Reviewer Applicant Potential Exclusion Criteria

A peer reviewer applicant, at the time of initial credentialing or re-credentialing, may be declined participation for the following:

1. Evidence of incompetence, meaning the gross or repeated deviation from the standard of care by failing to conform to minimal standards of acceptable and prevailing medical practice, or failure to maintain appropriate professional boundaries.
2. Evidence that the applicant has engaged in any unethical conduct, including actions likely to deceive, defraud or harm patients or the public.
3. Evidence that the applicant has been sanctioned, or has sanctions pending, by federal, state or local government programs.
4. Evidence that the applicant has personally engaged in or otherwise contributed to the submission of claims for payment that were false, negligently incorrect, intentionally duplicated or indicated other abusive billing practices.
5. Evidence that the applicant has engaged in any conduct resulting in a felony or gross misdemeanor conviction. For purposes of this provision, a plea of guilty or a plea of no contest to a felony or gross misdemeanor charge constitutes a conviction.
6. Evidence that the applicant has engaged in any sexual misconduct, or in any behavior toward a patient that could be reasonably interpreted by the patient as physical, emotional or sexual abuse or harassment.
7. Evidence of using or prescribing for self, or self-administration of any controlled substance, dangerous drug (as specified in law), or alcoholic beverages, that are dangerous or injurious to the applicant, any other person public, or that the practitioner's ability to practice safely is impaired by that use.
8. Evidence of repeated acts of clearly excessive prescribing, furnishing, administering of controlled substances, repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and the medical reason for prescribing (note that in no event shall a physician or surgeon who is lawfully treating intractable pain be reported for excessive prescribing).
9. Evidence that the applicant has had hospital privileges suspended or revoked for other than the failure to sign medical records.
10. Evidence that the applicant *does not hold* an active, unrestricted license or certification to practice medicine or a health profession in a state or territory of the United States.

Thank you for your interest in participating as a peer reviewer.

CREDENTIALING / RE-CREDENTIALING APPLICATION

Identification Information:

Last Name: **First Name:** **Middle Initial:**

Prefix: ☐Dr. ☐Mr. ☐Ms. **Suffix (Jr., Sr., etc.):** **Title (e.g., MD, RN, MSW):**

SSN # **NPI #** **Tax ID #:** ☐Business ☐Personal

Home Information *If your preference is that we contact you at home,* ***check here*** ☐
Preferred Contact: ☐ E-mail ☐ Pager ☐ Cell phone ☐ Phone

Address 1: **Address 2:**
City: **State:** **Zip:** **County:**
Phone: **Fax:** **Pager:** **Cell Phone:**
E-mail: ☐ *This is my preferred e-mail contact.*

Office Information *If your preference is that we contact you at the office,* ***check here*** ☐
Preferred Contact: ☐ E-mail ☐ Pager ☐ Cell phone ☐ Phone

Business Name: **Contact Person:** **Contact Title:**
E-mail: ☐ *This is my preferred e-mail contact.*
Address 1: **Address 2:**
City: **State:**
Phone: **Cell Phone:**

Affiliations
#1: **Facility:** **City:** **State:**
Do you have a staff affiliation? ☐ Yes ☐ No
If yes, what type of privileges? ☐ Attending ☐ Admitting ☐ Courtesy ☐ Manager/Officer ☐ Owner/Partner
Do you have a financial interest in this facility? ☐ Yes ☐ No

#2: **Facility:** **City:** **State:**
Do you have a staff affiliation? ☐ Yes ☐ No
If yes, what type of privileges? ☐ Attending ☐ Admitting ☐ Courtesy ☐ Manager/Officer ☐ Owner/Partner
Do you have a financial interest in this facility? ☐ Yes ☐ No

For additional affiliations, please list information below:

Licensure Information

☐ **Physician** ☐ **Allied Health**

#1: **License #:** **Type:** **State:** **Expiration Date:**

☐ Expired, not renewing ☐ *This is a restricted license*

#2: **License #:** **Type:** **State:** **Expiration Date:**

☐ Expired, not renewing ☐ *This is a restricted license*

For additional licenses, please list information below:

Board Certified Specialties (MDs and DOs only)

Specialty: **Effective Date:**

☐ This is a **time-limited** certification & expires: ☐ This is a **life-time** certification

☐ *I am willing to review this specialty.*

Subspecialty: **Effective Date:**

☐ This is a **time-limited** certification & expires: ☐ This is a **life-time** certification

Specialty: **Effective Date:**

☐ This is a **time-limited** certification & expires: ☐ This is a **life-time** certification

☐ *I am willing to review this specialty.*

Subspecialty: **Effective Date:**

☐ This is a **time-limited** certification & expires: ☐ This is a **life-time** certification

For additional specialties/subspecialties, please list information below:

Special Qualifications

Please provide a list of your special qualifications.

- For **Allied Health** professionals, please identify your certifications.
- For all applicants, please identify expertise you offer KEPRO (Examples: Languages other than English, expertise with particular settings, experience in specific contracts, such as HRSA or BFCC areas). Type as many as you have, separated by commas.

General Questions

1. Are you currently involved in active practice? ☐ Yes ☐ No
   If yes, please estimate your average hours per week:
2. Are you currently involved in clinical teaching? ☐ Yes ☐ No
   If yes, please estimate your average hours per week:
3. Have you ever provided direct patient care? ☐ Yes Date: _ _/_ _/_ _ _ _ ☐ No
   If yes, enter the date you started providing direct patient care:
   (Note: If your direct patient care has had periods of interruption, please enter the date that you most recently started providing direct patient care.)
4. Do you currently provide direct patient care? ☐ Yes ☐ No
   If yes, please estimate how many hours per week:
   If no, please indicate month and year you stopped providing direct patient care:
5. Do you have any gaps in work history? ☐ Yes ☐ No If yes, please explain below. Please specify the amount of time that lapsed in work history, if greater than three months.

6. Have your privileges to practice been abridged or suspended in any way, or is any action now pending?
   ☐ Yes ☐ No If yes, please explain below.

7. Do you currently have any charges or sanctions filed against you in a criminal, civil, or administrative proceeding; or, do you have reason to believe that such charges or sanctions will be filed? ☐ Yes ☐ No If yes, please explain below.

8. Have you ever entered a plea of guilty or nolo contendere where the offense involved the use or delivery of a controlled substance? ☐ Yes ☐ No If your conviction has been expunged, please answer "No."
9. Have you ever been enrolled in any Professional Health Monitoring Program ("PHMP")? ☐ Yes ☐ No If *Yes*, please provide the reason for your participation and the dates in which you were in PHMP. If yes, have you successfully completed the program? ☐ Yes ☐ No

10. Do you have utilization/quality assurance or peer review experience? ☐ Yes ☐ No
    If yes, give area of expertise and number of years' experience:
11. Are you willing to testify? ☐ Yes ☐ No
12. Do you have ABQAURP certification? ☐ Yes ☐ No Date of certification:
13. Do you possess basic computer skills? ☐ Yes ☐ No
14. Do have access to high-speed internet? ☐ Yes ☐ No
15. Are you willing to complete Expedited Reviews? ☐ Yes ☐ No

Contracts

Please identify the contracts and review types for each contract for which you are willing and able to perform reviews:

Contract	☐ BFCC QIO	☐ Commercial	☐ Federal	☐ Medicaid
Area/ Reviews	☐ Appeals ☐ Quality of Care ☐ UM/Peer Review	☐ Appeals/ Grievances ☐ Conflict of Interest (COI) ☐ Ind Medical Exam (IME) ☐ IRO Appeals ☐ UM/Peer Review	☐ Appeals/ Grievances ☐ Conflict of Interest (COI) ☐ Ind Medical Exam (IME) ☐ UM/Peer Review	☐ Appeals/ Grievances ☐ Conflict of Interest (COI) ☐ Ind Medical Exam (IME) ☐ UM/Peer Review

Small Business Information

In order to comply with Federal Government Contracting regulations, Keystone Peer Review Organization, Inc. (KEPRO) is required to identify those who provide services who have special certifications/classifications. A brief description of each classification is listed below each question to help simplify your response. This information is required for payment processing.

If payment for services will be made directly to you, you are considered to be the business concern, <u>not</u> your group or employer. Average annual receipts include your total income, excluding net capital gains or losses. If this amount is ***less*** than $11.0 million, then you are considered to be a small business concern.

1. Are you a small business concern as defined by SBA? ☐ Yes ☐ No ☐ Don't Know
   A business organized for profit, located in the U.S., and has a 3 year averaged annual gross revenues less than $11.0 million for physician offices and mental health specialists and all other health practitioners/offices.

If you answered "yes" to the above question, please answer questions 2-8. If "no," please sign and date below.

2. A woman owned small business? ☐ Yes ☐ No ☐ Don't Know

   At least 51% owned by one or more women and whose daily operations are controlled by one or more women.

3. A HUBZone Small Business? ☐ Yes ☐ No ☐ Don't Know

   A business located in a historically underutilized business zone, owned and controlled by one or more U.S. citizen and where at least 35% of its employees reside in a HUBZone.

4. A Self-Certified Business? ☐ Yes ☐ No ☐ Don't Know

   At least 51% owned and controlled by an economically and socially disadvantaged individual(s) and an individual's net worth must be less than $750,000 excluding equity in the business and primary residence.

5. A Veteran Owned Small Business? ☐ Yes ☐ No ☐ Don't Know

   At least 51% owned and controlled by a person defined as a veteran (served in active duty) who was discharged or released from under conditions other than dishonorable.

6. Service Disabled Veteran Owned Small Business? ☐ Yes ☐ No ☐ Don't Know

   Same as above. Service disabled defined as a disability that is service-connected.

   A spouse may qualify if the veteran has a permanent and severe disability.

Note: Any firm that has misrepresented its status in the above listed categories in order to obtain a subcontract from Keystone Peer Review Organization, Inc., will be subject to the punishments as defined in 115 U.S.C.645(d) and FAR 52-219-9 (e).

Signature of this form constitutes certification of compliance with all provisions within this form.

_____ _____

Signature of Peer Reviewer Date

Printed Name/Title of Peer Reviewer

Federal Contracting Designation Definitions

1. **Small Business Concern** — A business concern eligible for assistance from SBA as a small business is one that is organized for profit, with a place of business located in the United States. It must operate primarily within the United States or make a significant contribution to the U.S. economy through payment of taxes or use of American products, materials or labor. Together with its affiliates, it must meet the numerical size standards as defined in the Small Business Size Regulations, 13 CFR 121. For more information, please go to http://www.sba.gov/content/am-i-small-business-concern/.

2. **Woman-Owned Small Business** — A business that meets the following criteria: (a) Is at least 51 percent owned by one or more women; or, in the case of any publicly owned business, at least 51 percent of the stock of which is owned by one or more women; and (b) Whose management and daily business operations are controlled by one or more women." For more information, please go to https://www.sba.gov/content/women-owned-small-business-program.

3. **HUBZone** — Historically Underutilized Business Zone. To qualify as a HUBZone small business concern the firm must be: (a) Small; (b) Located in a "historically underutilized business zone" (HUBZone); (c) Owned and controlled by one or more U.S. Citizens; and, (d) One that at least 35 percent of its employees reside in a HUBZone. For more information, please go to https://www.sba.gov/category/navigation-structure/contracting/contracting-support-small-businesses/small-business-cert-0.

4. **Self-Certified Business** — A small business must be at least 51 percent owned and controlled by a socially and economically disadvantaged individual or individuals. African Americans, Hispanic Americans, Asian Pacific Americans, Subcontinent Asian Americans, and Native Americans are presumed to qualify. Other individuals can qualify if they show by a preponderance of evidence that they are disadvantaged. All individuals must have a net worth of less than $750,000, excluding the equity of the business and primary residence. Successful applicants must also meet applicable size standards for small businesses in their industry. For more information, please go to https://www.sba.gov/offices/headquarters/obd/resources/4210.

5. **Veteran Owned Small Business** — A small business concern where: (A) Not less than 51 percent of which is owned by one or more veterans (as defined at 38 U.S.C. 101(2)) or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more veterans; and (B) The management and daily business operations of which are controlled by one or more veterans. According to 38 U.S.C. 101 (2), “veteran” is defined as “a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.” For more information, please go to http://www.vetbiz.gov/.

6. **Service Disabled Veteran Owned Small Business** — A small business concern where: (A) Not less than 51 percent of which is owned by one or more service-disabled veterans or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more service-disabled veterans; and (B) The management and daily business operations of which are controlled by one or more service-disabled veterans or, in the case of a veteran with permanent and severe disability, the spouse or permanent caregiver of such veteran. A service-disable veteran means a veteran, as defined in 38 U.S.C. 101(2), with a disability that is service- connected, as defined in 38 U.S.C. 101(16). From U.S.C. 101 (16), the phrase service connected (in terms of service disabled) means: “with respect to disability or death, that such disability was incurred or aggravated, or that the death resulted from a disability incurred or aggravated, in line of duty in the active military, naval, or air service.” For more information, please go to http://www.vetbiz.gov/.

REVIEW AGREEMENT

My signature at the conclusion of this agreement indicates my willingness to participate as a Peer Reviewer when requested by KEPRO or its subsidiaries and to conduct reviews in accordance with the applicable contract, URAC, or state mandated time frames.

I understand that KEPRO is relying upon the current accuracy of the information contained in my Peer Reviewer Application, and will continue to rely upon its accuracy in deciding whether to request my services as a reviewer.

I further understand that I will be compensated for my peer review services based on the type of review or service and/or amount allowed by the individual contract and that compensation to me as a Peer Reviewer for any provision of the services required hereunder does not contain direct or indirect incentives to make inappropriate review decisions.

I agree to maintain and safeguard the confidentiality of all medical records and data received by me relevant to the performance review activities. I further agree to promptly advise KEPRO of any issue with respect to a conflict of interest or perceived conflict of interest in connection with review activities.

I also agree to fully cooperate with KEPRO and client personnel in connection with preparation of all time logs, administrative forms, review reports, depositions, and other oral or written testimony, which may be required in connection with my review activities.

I agree to notify KEPRO within three (3) business days of any changes regarding my credentials or contact information noted within this application, as well as any changes or restrictions to licensure, Drug Enforcement Administration (DEA) registration, and professional board certifications. Except to the extent specifically modified by this Agreement, I hereby ratify and affirm all authorizations, applications, consents, and agreements executed by me in connection with my acceptance by KEPRO as a reviewer under the Social Security Act and other applicable regulations.

_____

Signature of Peer Reviewer **Date**

HIPAA/CONFIDENTIALITY AGREEMENT - PEER REVIEWERS

KEPRO has entered into a Business Associate Agreement with a Covered Entity subject to the Health Insurance Portability and Accountability Act of 1996 and its implementing simplification regulations (45 CFR §§ 160-164) ("HIPAA") which, among other restrictions and conditions, establish permitted uses and disclosures of Protected Health Information ("PHI").

Pursuant to the terms of the Business Associate Agreement, KEPRO is required to ensure that its agents (e.g., peer reviewers) and subcontractors agree to the same restrictions and conditions that apply to KEPRO with respect to PHI.

In the course of providing peer review services for KEPRO, you may create or receive PHI from or on behalf of KEPRO, or a Covered Entity, or have access to PHI. Therefore, the following restrictions and conditions with respect to PHI apply to you as a Peer Reviewer:

I. DEFINITIONS

Terms used but not otherwise defined in this HIPAA Agreement shall have the same meaning as those terms in 45 C.F.R. §§ 160.103 and 164.501.

II. PERMITTED USES AND DISCLOSURES:

Except as otherwise limited in this HIPAA Agreement, a Peer Reviewer may use or disclose PHI (1) to perform functions, activities, or services for, or on behalf of, KEPRO and/or Covered Entity as directed by KEPRO or in this HIPAA Amendment, provided that such use or disclosure would not violate HIPAA if made by KEPRO or Covered Entity or (2) as required or permitted by applicable law, rule, regulation, or regulatory agency or by any accrediting or credentialing organization to whom the Covered Entity, KEPRO or the Peer Reviewer is required to disclose such PHI. In addition,

(i) Peer Reviewer may disclose PHI, if necessary, if the following requirements are met:

(a) The disclosure is required by law; or

(b) Peer reviewer obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies Peer Reviewer of any instances of which it is aware in which the confidentiality of the PHI has been breached.

(ii) Peer Reviewer may use PHI to provide Data Aggregation services to KEPRO or Covered Entity as permitted by HIPAA.

(B) Restrictions: Peer Reviewer shall not use or disclose PHI for any other purpose not described above.

(C) Appropriate Safeguards: Peer Reviewer shall implement appropriate and reasonable safeguards to prevent use or disclosure of PHI other than as permitted in this HIPAA Amendment. When reviews are performed at a location other than the KEPRO office (i.e., at a reviewer's home or office), confidential information will be transported under reasonable security, as follows:

1. When confidential information is transported offsite, the vehicle will be locked. Confidential information must be placed in a locked trunk whenever possible. If the vehicle does not have a trunk, the information must be kept in a covered container (i.e., a box with a lid). Unattended confidential information will be stored under lock and key.

2. When using public transportation, confidential information must be carried in a locked briefcase or suitcase or in a covered container.

3. Any confidential information mailed to or from offsite locations must be properly packaged and deposited in an official United States Post Office receptacle, delivered directly to a post office, or mailed using a mailing service which has been approved by KEPRO. The information must not be placed in private mailbox for pick-up.

(D) Reporting of Improper Use or Disclosure: Peer Reviewer shall report to KEPRO in writing any use or disclosure of PHI of which he/she becomes aware that is not in compliance with the terms of this HIPAA agreement.

(E) Mitigation: Peer Reviewer shall mitigate, to the extent practicable, any harmful effect that is known to the peer reviewer of a use or disclosure of PHI in violation of the requirements of this HIPAA agreement.

III. TERMINATION:

(A) Term: The Term of this HIPAA agreement shall be effective as of the date set forth below and shall terminate when Peer Reviewer ceases to perform peer review services for KEPRO, however, that certain obligations shall survive termination of this HIPAA agreement as set forth in Section III(C).

(B) Termination for Cause: In the event that a Peer Reviewer materially breaches any provision of this HIPAA agreement and fails to cure or take substantial steps to cure

such material breach to KEPRO's satisfaction within thirty (30) days after receipt of written notice from KEPRO, KEPRO will terminate the services of the Peer Reviewer.

(C) Return or Destruction of PHI: Upon termination, if feasible, Peer Reviewer shall return or destroy all PHI received from, or created or received on behalf of, KEPRO and/or Covered Entity that the peer reviewer still maintains in any form and shall retain no copies of such information. Prior to doing so, Peer Reviewer further agrees to recover any PHI in the possession of its subcontractors or agents. If it is not feasible to return or destroy PHI, Peer Reviewer shall provide to KEPRO notification of the conditions that make return or destruction of PHI infeasible. Peer Reviewer shall continue to extend the protections of this HIPAA agreement to such PHI, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible.

IV. MISCELLANEOUS

(A) No Third Party Beneficiaries: Nothing expressed or implied in this HIPAA Agreement is intended to confer, nor shall anything herein confer, upon any person other than KEPRO, the Peer Reviewer and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

(B) Governing Law: This HIPAA Agreement shall be governed by and construed in accordance with the substantive law of the Commonwealth of Pennsylvania without regard to conflicts of laws, unless parties mutually agree to change governing law.

V. INDEMNIFICATION

The Parties agree to indemnify, defend and hold harmless each other and each other's respective employees, directors, officers, subcontractors, agents or other members of each other's workforce (collectively referred to as the "Indemnified Party"), against all costs suffered by the Indemnified Party, including but not limited to any and all actual and direct losses, liabilities, fines, penalties, costs or expenses (including reasonable attorneys' fees), arising from or in connection with a material breach of this HIPAA agreement by the Indemnifying Party. This provision shall survive the expiration or termination of this HIPAA agreement.

1. I have received, read and understand KEPRO's restrictions and conditions with respect to PHI, as detailed in this agreement.

2. I will conduct myself in accordance with these restrictions and conditions.

3. I understand that to violate these restrictions and condition will lead to immediate termination of my services by KEPRO.

4. I also understand that unauthorized disclosures of medical information or PHI may lead to:

a. a fine of not more than $1,000 and/or imprisonment for not more than six months, under the Social Security Act;

b. criminal penalties with a maximum fine of $250,000 and up to ten years in prison for misuse of such information and civil penalties up to $100 per person per violation.

_____

Signature

Date

Please print your name clearly on the following line:

AUTHORITY TO RELEASE INFORMATION

NOTE: *This Release must be completed by all applicants in order to assure authorized release of confidential credentialing information.*

In applying for appointment as a Peer Reviewer or consultant to KEPRO and/or its subsidiaries, I, _____ hereby authorize KEPRO, or it representatives, to consult with

Name of Applicant

health care facilities with which I have been associated and with others who may have information bearing on my professional qualifications, clinical competence, credentials, behavior or any other matters which may be relevant to my appointment as a Peer Reviewer. I release from any liability all representatives of KEPRO for their acts performed in good faith, and without malice in connection with evaluating me and my credentials, and release from liability all individuals and organizations who provide information to KEPRO, or its designees, in good faith and without malice concerning my professional qualifications, clinical competence, credentials, behavior and other qualifications which may be relevant to my appointment as Peer Reviewer, including otherwise privileged or confidential information.

_____ _____

Signature of Applicant **Date**