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AUTHORIZATION TO RELEASE INFORMATION

In furtherance of my facility's application for accreditation and continued accreditation by the American Association for Accreditation of Ambulatory Surgery Facilities, Inc., I hereby request and authorize any hospital, any medical staff or any other medical organization with which I am now or have been affiliated to provide information concerning my current or former status with such organization(s). I hereby release from liability any hospital, medical staff or other medical organization for acts performed in connection with the collection of evaluation and submission of such information concerning my status to the American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

____
Name

X ____
Signature

____________________ ____________________
Date Facility I.D. #