

PARK PLACE SURGICAL HOSPITAL  
Delineation of Privileges  
DEPARTMENT OF SURGERY  
**UROLOGY SERVICE**

<u>Privileges Requested</u>	<u>Privileges Approved</u>	
_____	_____	<b>ABDOMEN</b>
_____	_____	Drain Abscess, Retroperitoneal
_____	_____	Excision Tumor, Retroperitoneal
_____	_____	Excision Cyst, Retroperitoneal
_____	_____	Exploratory Laparotomy
_____	_____	Closure of Evisceration
_____	_____	Herniorrhaphy, Incisional
_____	_____	Appendectomy
_____	_____	Splenectomy
_____	_____	Other _____
_____	_____	<b>ADRENAL</b>
_____	_____	Exploration of Adrenal
_____	_____	Adrenalectomy, Pheochromocytoma
_____	_____	Adrenalectomy, Aldosterone
_____	_____	Adrenalectomy, Cortical Tumor
_____	_____	Adrenalectomy, Bilateral
_____	_____	Other _____
_____	_____	<b>BLADDER</b>
_____	_____	Cystostomy, Open
_____	_____	Cystostomy, Trochar
_____	_____	Closure Cystostomy
_____	_____	Cystolithotomy
_____	_____	Excision Urachal Cyst or Tumor
_____	_____	Diverticulectomy
_____	_____	Cystectomy, Partial
_____	_____	Cystectomy, Partial Plus Ureteroneocystostomy
_____	_____	Cystectomy, Simple
_____	_____	Cystectomy, Simple Plus Ileal Conduit
_____	_____	Cystectomy, Simple Plus Ureteroneocystostomy
_____	_____	Cystectomy, Simple Plus Cutaneous Ureterostomy
_____	_____	Cystectomy, Radical Plus Ileal Conduit

<u>Privileges Requested</u>	<u>Privileges Approved</u>	
_____	_____	<b>BLADDER (cont.)</b>
_____	_____	Cystectomy, Radical Plus Colon Conduit
_____	_____	Cystectomy, Radical Plus Ureterosigmoidostomy
_____	_____	Cystectomy, Radical Plus Continent Diversion
_____	_____	Pelvic Exenteration Plus Urinary Diversion
_____	_____	Vesical Neck Plasty
_____	_____	Vesical Neck Plasty Plus Ureteroneocystostomy
_____	_____	Anterior Urethropexy (Marshall-Marchetti)
_____	_____	Vaginal Urethropexy (Stamye-Raz)
_____	_____	Repair of Rupture
_____	_____	Closure of Vesicovaginal Fistula, Abdominal
_____	_____	Closure of Vesicovaginal Fistula, Vaginal
_____	_____	Closure of Enterovesical Fistula
_____	_____	Closure of Extrophy of Bladder, Initial
_____	_____	Repair of Extrophy, Continence Procedure
_____	_____	Enterocystoplasty
_____	_____	Vesicostomy
_____	_____	Urodynamics
_____	_____	Other _____
_____	_____	<b>ENDOSCOPY</b>
_____	_____	TUR Sphincterotomy Insertion of Stent
_____	_____	TUR Insertion of Radioactive Material
_____	_____	TUR, Prostate
_____	_____	Cystoscopy, TUR, Bladder Tumor
_____	_____	Cystoscopy
_____	_____	Cystoscopy Plus Ureteral Catheterization
_____	_____	Cystoscopy Plus Cup Biopsy Bladder
_____	_____	Cystoscopy and Fulguration
_____	_____	Cystoscopy, Calibration and Dilation, Stricture
_____	_____	Cystoscopy, Litholapaxy
_____	_____	Cystoscopy, Removal of Foreign Body
_____	_____	Cystoscopy, Extraction Ureteral Calculus
_____	_____	Cystoscopy, Hydrodistention of Bladder
_____	_____	Cystoscopy, TUR, Urethral Valves
_____	_____	Other _____

<u>Privileges Requested</u>	<u>Privileges Approved</u>	
_____	_____	<b>EPIDIDYMIS AND SPERMATIC CORD</b>
_____	_____	I & D
_____	_____	Vasovasostomy
_____	_____	Ligation Internal Spermatic Vein
_____	_____	Biopsy Epididymis
_____	_____	Excision Lesion Epididymis
_____	_____	Excision Spermatocele
_____	_____	Epididymectomy
_____	_____	Other _____
_____	_____	<b>KIDNEY</b>
_____	_____	Drainage of Abscess, Perirenal or Renal
_____	_____	Nephrostomy, Open
_____	_____	Nephrolithotomy, Simple
_____	_____	Nephrolithotomy, Staghorn
_____	_____	Percutaneous Nephrolithotomy
_____	_____	Pyelolithotomy
_____	_____	Biopsy, Open
_____	_____	Nephrectomy, Unilateral, Simple
_____	_____	Nephrectomy, Bilateral, Simple
_____	_____	Nephrectomy, Plus Regional Lymphadenectomy
_____	_____	Nephrectomy, Partial
_____	_____	Nephroureterectomy
_____	_____	Heminephroureterectomy
_____	_____	Exploration for Cyst
_____	_____	Pyeloplasty
_____	_____	Pyeloplasty Plus Symphysiotomy
_____	_____	Percutaneous Endopyeloplasty
_____	_____	Closure Nephrocutaneous Fistula
_____	_____	Homotransplantation
_____	_____	Autotransplantation
_____	_____	Harvest of Cadaver Kidneys
_____	_____	Nephrectomy, Donor
_____	_____	Percutaneous Nephrostomy
_____	_____	Percutaneous Nephroscopy
_____	_____	ESWL

<u>Privileges Requested</u>	<u>Privileges Approved</u>	
_____	_____	<b>KIDNEY cont.</b>
_____	_____	Biopsy, Needle
_____	_____	Other _____
_____	_____	 <b>LYMPHATIC</b>
_____	_____	Lymphadenectomy, Pelvic
_____	_____	Lymphadenectomy, Inguinal
_____	_____	Lymphadenectomy, Ilioinguinal
_____	_____	Lymphadenectomy, Retroperitoneal
_____	_____	Lymph Node Biopsy
_____	_____	Laser and Other Destruction
_____	_____	Other _____
_____	_____	 <b>PENIS</b>
_____	_____	Amputation, Partial
_____	_____	Amputation, Complete
_____	_____	Amputation With Ilioinguinal Lymphadenectomy
_____	_____	Amputation With Inguinal Lymphadenectomy
_____	_____	Correction of Chordee Without Hypospadias
_____	_____	Repair of Epispadias With Incontinence
_____	_____	Insertion Penile Prosthesis
_____	_____	Repair Penile Injury
_____	_____	Shunt, Cavernosum to Spongiosum, Open
_____	_____	Shunt, Cavernosum to Spongiosum, Percutaneous
_____	_____	Shunt, Cavernosum to Saphenous Vein
_____	_____	Revascularization, Microsurgery
_____	_____	Dorsal Slit
_____	_____	Circumcision
_____	_____	Biopsy Penis
_____	_____	Other _____
_____	_____	 <b>PROSTATE</b>
_____	_____	Balloon Dilatation
_____	_____	Open Biopsy
_____	_____	Prostatectomy, Perineal, Simple
_____	_____	Prostatectomy, Perineal, Radical

Privileges  
Requested

Privileges  
Approved

**PROSTATE cont.**

_____	_____	Prostatectomy, Retropubic, Radical
_____	_____	Prostatectomy, Suprapubic
_____	_____	Open Insertion of Radioactive Materials
_____	_____	Needle Biopsy
_____	_____	I & D Prostatic Abscess
_____	_____	Other _____

**RENOVASCULAR (In consultation with Vascular Surgeon.)**

_____	_____	Embolectomy
_____	_____	Endarterectomy, Renal Artery
_____	_____	Reimplantation, Aorto-Renal
_____	_____	Bypass Graft, Aorto-Renal
_____	_____	Bypass, Spleno-Renal
_____	_____	Resection and Reanastomosis, Renal Artery
_____	_____	Aneurysmectomy, Renal Artery
_____	_____	Other _____

**SCROTUM**

_____	_____	Excision, Complete
_____	_____	Incise and Drain Abscess
_____	_____	Hydrocelectomy
_____	_____	Repair Scrotum (Trauma)
_____	_____	Excision, Partial
_____	_____	Biopsy
_____	_____	Other _____

**TESTIS**

_____	_____	Orchiectomy, Inguinal
_____	_____	Orchidopexy, Unilateral
_____	_____	Orchidopexy, Bilateral
_____	_____	Biopsy, Testis
_____	_____	Abdominal Exploration for UDT
_____	_____	Biopsy Plus Vasogram
_____	_____	Excision Lesion of Testis
_____	_____	Orchiectomy, Simple, Unilateral or Bilateral
_____	_____	Insertion Testicular Prosthesis



\_\_\_\_\_  
Urology Service

Magpi/Mathieu

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Privileges  
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Privileges  
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**URETHRA cont.**

_____	_____	Major Urethroplasty
_____	_____	Total Complex Repair
_____	_____	Meatoplasty
_____	_____	Fistula Repair
_____	_____	Closure Urethrocutaneous Fistula
_____	_____	Reconstruction for Incontinence
_____	_____	Prosthesis for Urinary Incontinence
_____	_____	Closure, Urethro-Vaginal Fistula
_____	_____	Closure, Urethro-Rectal Fistula
_____	_____	Repair Urethral Injury
_____	_____	Repair of Epispadias
_____	_____	Repair of Epispadias With Incontinence
_____	_____	Urethrostomy, Internal
_____	_____	Urethrostomy, External
_____	_____	Urethrostomy, Perineal
_____	_____	Meatotomy
_____	_____	Incise and Drain Periurethral Abscess
_____	_____	Biopsy of Urethra
_____	_____	Excision of Urethral Prolapse
_____	_____	Other _____

**SEXUAL MEDICINE**

_____	_____	Surgical Treatment (Venous Ligation)
_____	_____	Yohimbine
_____	_____	Penile Injections
_____	_____	Suction Devices

**IMPLANTS**

_____	_____	Semi Rigid Implant
_____	_____	Inflatable Implant
_____	_____	Self Contained Implant

**CONSCIOUS SEDATION (11)**

\_\_\_\_\_  
Applicant's Signature/Date

\_\_\_\_\_  
Medical Director's Signature/Date



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**HOSPITAL SERVICES CORPORATION  
CREDENTIALS VERIFICATION SERVICE  
DESIGNATION AND AUTHORIZATION FOR RELEASE AND REDISCLOSURE OF INFORMATION  
("Release")**

**Authority to Release:** I have applied to participate as a provider for \_\_\_\_\_

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Print the names of all organizations to which you are applying.

and its authorized representatives (hereafter "Health Care Entity") which has designated Hospital Services Corporation's Credentials Verification Service ("HSC") as their agent. I consent to complete disclosure by the recipient of this release to HSC of all relevant information pertaining to my professional qualifications, moral character, physical and mental health (hereinafter "qualifications"). I authorize the recipient to make available and/or disclose to HSC all such information in its files from any university, professional school, licensing authority, accreditation board, hospital, physician, dentist, professional society, insurance carrier, law enforcement agency, military service, or any other person or entity deemed necessary or appropriate in the investigation and processing of my application.

I request and authorize the recipient to release the requested information and I expressly waive any claim of privilege or privacy with respect to the released information bearing on my admission to, retention or termination of medical staff appointment or clinical privileges. I release and discharge HSC, the Health Care Entity and the medical, dental, podiatry and ancillary staffs or panels, credentials committees, administrators, review and approval boards or committees, governing boards, whether or not designated by these titles, and their agents, servants or employees authorized by representatives and all other persons or entities supplying information to them from liability or claims of any kind or character in any way arising out of inquiries concerning me or disclosures made in good faith in connection with my application for appointment to the Health Care Entity's Medical Staff or Provider Panel.

**Authority to Redisclose:** Unless I have denied authority by initialing here \_\_\_\_\_, I authorize the Health Care Entity, the Health Care Entity's Authorized Representatives, and HSC to redisclose information concerning my qualifications, or credentials and privileges to third parties who have a need to know the information (1) based upon state or federal laws or regulations, or (2) pursuant to any health care provider agreement to which I am or will be a party and in which I have an interest as an individual health care provider, or (3) to participate in the common recredentials program, if applicable.

This Release does not authorize HSC to disclose information about my qualifications to any claimant. If a claimant requests information from HSC about me or if a subpoena duces tecum is served upon HSC seeking information about me, which is in HSC's possession, I understand I will be notified immediately. If I direct HSC to resist the subpoena, I hereby agree to indemnify and hold harmless HSC, its officers, directors, employees and agents for all attorney fees, costs, fines, and expenses incurred in resisting the subpoena at my request.

This authorization is limited to the acquisition and disclosure of information required by state or federal law, and information which is acquired or disclosed pursuant to activities protected by the state's Review Organizational Immunity Act and the Health Care Quality Improvement Act of 1986. A photocopy of this Designation and Authorization for release and redisclosure of information shall be considered by the recipient to be a signed original, as long as it is transmitted to the recipient by HSC and is received within five years of its date.

**The certain definitions used in this Release and set forth on the following page of this application are incorporated by reference. I understand that I may withdraw or modify this authorization at any time in writing by submitting a written request to HSC. PHOTOCOPY BOTH PAGES OF THIS FORM.**

**Signature stamps and date stamps are not acceptable.**

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Applicant Signature

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Printed Name

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Date (do not type)

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**DEFINITIONS** of terms used in this Designation and Authorization for Release and Redisclosure of information.

"Health Care Entity" is the Health Care Entity on the front of this form.

The "Health Care Entity's Authorized Representatives" include any management or quality assurance companies hired by the Health Care Entity or HSC; the Health Care Entity's Board, staffs, committees, CEO, administrator medical director or other employees of the Health Care Entity whose performance of duties requires access to information about my qualifications; consultants whose contract with the Health Care Entity requires access to information about my qualifications; any independent credentialing services including HSC; and the Health Care Entity's attorneys and insurers.

"Credentials and Privileges" means all information regarding my qualifications, my standing with the Health Care Entity, and my right to provide healthcare services at or through the Healthcare Entity. It also includes any limitations imposed upon my right to provide healthcare services and any final disciplinary action taken by the Health Care Entity with regard to my provision of healthcare services at or through the Healthcare Entity.

"Credentialing Verification Service" is the service operated by Hospital Services Corporation. HSC may be required as a condition of certification by the National Committee for Quality Assurance (NCQA) to permit audits of HSC's system. The person providing this Release acknowledges that these audits are conducted solely for the purpose of certifying the credentialing verification service, and all information utilized by the NCQA is treated as confidential.

"Claimant" means any person, guardian, or personal representative who is asserting an administrative or legal claim against the person providing this release based in whole or in part upon allegations that the person providing this release has violated any state or federal law or regulation or has committed medical malpractice.

"Medical Staff or Provider Panel" is to be interpreted broadly to include any group of healthcare providers howsoever designated, who are authorized to provide healthcare services to patients, insureds, beneficiaries, members, or enrollees of a healthcare plan.

"Third Parties who have a need to know" include, but are not limited to governmental agencies and boards; organizations, associations, partnerships, corporations; other hospitals and clinics; managed care organizations, Independent Practice Associations ("IPA's"), Managed Service Organizations ("MSO's"), Physician Hospital Organizations ("PHO's"), Preferred Provider Organizations ("PPO's"), Health Maintenance Organizations ("HMO's"), medical foundations, insurance underwriters, employer or employee sponsored ERISA health plans, health care alliances, or others with whom I am negotiating a health care provider agreement, presently have a health care provider agreement or with whom the Health Care Entity identified on the front page of this authorization (or the Health Care Entity's Authorized Representatives) is negotiating a health care provider agreement or has health care provider agreement in which I have or will acquire an interest.

"Common Recredentials Program" has been developed to allow this application to be utilized for multiple requesting customers to both expedite processing and reduce provider paperwork.