Attachment I

Northwest Community Health Partners

CONSENT FOR RELEASE OF INFORMATION/RELEASE FROM LIABILITY

I hereby give permission to Northwest Community Health Partners (PHO), its affiliates and the employees, agents and representatives thereof to obtain information about my professional education, training, licensing, competence, ethics, character and other qualifications. I consent to the release of such information, whether in the form of transcripts, records tapes, letters, photocopies/duplications of any of the foregoing, verbal statements, by hospital administrators, chiefs of clinical departments of hospitals in which I have served on staff, state licensing boards or regulatory bodies (by whatever name known in their respective jurisdictions), physicians, clinics, or other individuals or organizations who or which possess information about me. 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 any person or entity who or which provides the above described information as authorized herein.

I hereby release from liability and agree to hold harmless all employees, agents and representatives of the above named entity and its affiliates for their acts performed and statements made in connection with obtaining, reviewing, and evaluating my credential and qualifications. I further acknowledge that my cooperation by consenting to the production of such information about me does not guarantee that any of the above named entities or their affiliates will contract with me as provider of services to the insured or enrollees. The determination of whether I am 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.

I further agree that a photocopy of this document will serve as a duplicate original.

______________________________ ______________________________

(Signature) **(Date)**

____

(Print Name)

Northwest Community Health Partners

RELEASE OF INFORMATION AUTHORIZATION

I, ________________________________, hereby authorize the Northwest Community Health Partners (PHO) to release the following information (on a yearly basis), when requested by managed care plans with which whom the PHO contracts:

1. A copy of my Board Certification Letter or Certificate;
2. A copy of my current Medical License;
3. A copy of my current State DEA;
4. A copy of my current Federal DEA;
5. A copy of my current Liability Insurance Face Sheet, ***with expiration date.***
6. A copy of my completed Provider Application/Record Form.

This authorization shall be in effect for the duration of the term of my Agreement with Northwest Community Health Partners.

________________________________ ________________________________
Signature Date

____
Print Name