

**NORTHWEST COMMUNITY HEALTH PARTNERS  
RELEASE OF INFORMATION AUTHORIZATION**

I, \_\_\_\_\_, hereby authorize the Northwest Community Health Partners (NWHP) to release the following information (on a yearly basis), when requested by managed care plans with which whom NWHP 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)**