AUTHORIZATION FOR RELEASE OF INFORMATION and ATTESTATION

I have applied to be a participating provider with Independent Care Health Plan (*i*Care). In order for *i*Care to evaluate my qualifications, I authorize *i*Care and (its authorized representatives and agents to consult with any third party who may have information including information that otherwise may be privileged or confidential) relating to my professional qualifications, competence and conduct. I also authorize any such third party (including the credentials verification organization) to release such information, related reports and documents to *i*Care and its authorized representatives and agents upon request and receipt of a copy of this Authorization for Release of Information.

I certify that all information in my application is warranted to be true, accurate and complete. I also agree to immediately update *i*Care on any changes in the information submitted in my application and agree to provide such additional information and execute such additional forms as may be requested by *i*Care in order to evaluate my professional qualifications, competence and conduct.

As an applicant for credentialing or recredentialing with *i*Care, I have the right to review the information submitted in support of my credentialing application. I acknowledge that *i*Care will notify me of any information obtained during the credentialing process that varies substantially from the information I have provided to *i*Care and that I will have the right to correct any and all erroneous information in my application.

By submitting my application for credentialing or recredentialing with *i*Care, I agree to be bound by the terms of the Credentialing Plan, as it may be amended by *i*Care from time to time. I understand *i*Care will use this information solely in conjunction with my application for and status as a participating provider and that the information is not subject to re-disclosure except as permitted by Federal and State Law.

I hereby release from liability *i*Care and its directors, officers, employees and authorized representatives, including the credentialing agent and its directors, employees and representatives and agents and third parties for any acts performed in good faith in providing or receiving information, reports or other documents relating to or in evaluating, my professional qualifications, competence or conduct. This release from liability shall include but not be limited to, actions relating to the following:

- My application to be a participating provider with *i*Care
- Periodic appraisals undertaken for recredentialing, utilization review or otherwise for quality management; and
- Proceedings for termination, suspension or restriction of my status as a participating provider with *i*Care or any other disciplinary action.

This authorization is valid for 180 days and, if I become an *i*Care participating provider, for the time period that I remain an *i*Care provider.

Date: _____ _____

(Signature)

_____

(Printed Name)