



**ADVANTAGE Health Solutions, Inc. <sup>sm</sup>**

**ATTESTATION AND AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize ADVANTAGE Health Solutions, Inc. <sup>sm</sup>, its representatives, agents or designees, to obtain from any source, information and/or documents regarding my professional credentials and qualification related to this application for new or continued network provider privileges (hereinafter referred to as “Credentialing Information”).

I understand and agree that acceptance of this application does not constitute approval or acceptance of participating provider status for any ADVANTAGE contracted network, and grants me no rights or privileges of participation until such time as I receive actual written notice of acceptance and participating provider status. Termination of my request for application is not an adverse action within the reporting requirements of the National Practitioner Data Bank and does not entitle me to any appeal or hearing.

I understand that ADVANTAGE will conduct an independent verification of this Credentialing Information and such information will be used to evaluate my credentials according to ADVANTAGE standards. I hereby consent to the release of Credentialing Information to ADVANTAGE, its agents, representatives or designees. This authorization to release Credentialing Information shall include, but not be limited to, sources such as the medical staff office and/or Chief(s) of clinical Departments of any hospital or facility with which I have at any time been affiliated, all National Practitioner Data Bank and/or Peer Review Committee information and reports, including utilization review information, and information from professional boards, state regulatory and licensing agencies, professional societies, accrediting agencies, and any companies from which I have obtained professional liability insurance., I hereby release all third party sources of Credentialing Information from any and all liability related to the release of such information that is provided in good faith and without malice.

I hereby release and hold harmless from any and all liability all members of ADVANTAGE, the Board of Directors, it officers, agents, peer review committee members and employees, for all activities executed in good faith and without malice regarding the evaluation of my credentials and qualifications or the denial or termination of participating provider status in any ADVANTAGE contracted network, or ADVANTAGE.

A photocopy of this authorization will serve as an original. I understand that ADVANTAGE, the Credentialing Committee and/or their designees will utilize this information only in connection with my application for credentialing or re-credentialing purposes. I understand ADVANTAGE, its Credentialing Committee and their designees will treat this information as confidential.

***The undersigned certifies and attests that the forgoing is truthful, correct and complete in all respects, and the undersigned further understands the intentional submission of false or misleading information or the withholding of relevant information is grounds for denial or immediate termination from the ADVANTAGE provider networks. The undersigned hereby agrees to report to ADVANTAGE any changes in the above information within thirty (30) days of change.***

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
APPLICANTS SIGNATURE

\_\_\_\_\_  
DATE