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**RELEASE AUTHORIZATION**

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**PLEASE READ AND UNDERSTAND THE FOLLOWING AGREEMENT BEFORE SIGNING THIS INQUIRY**

I certify that all of the information submitted by me in this document is true and complete to the best of my knowledge and belief.

I understand that any misstatement in or omissions from this document constitutes cause for denial or termination of participation in ActivHealthCare network.

I understand that I have the right to correct information used in the initial credentialing or recredentialing process, including information submitted by myself or another party. This right does not extend to information prohibited from release by statute, such as NPDB report or peer review documents. If the Plan has received conflicting information from a third party, I will be notified via the Credentialing Supervisor at ActivHealthCare.

I understand that this application does not entitle me to participation in the network of any health plan using the application. I agree that any health plan using this application, their representatives, and any individuals or entities providing information to such health plan in good faith shall not be liable for any act or omission related to the evaluation or verification contained in this application. I further agree to notify the health plan with which I participate and which use this application about any changes to the information provided in this application by the next business day. Information requested in this application that is not publicly available will be treated as confidential by the health plan using it.

I authorize ActivHealthCare, or its designated representative, to contact and consult with administrators, administrative staff, licensing organizations and professional peers at institutions and health care or other organizations with which I am or have been associated, and with past and present insurance carriers, who may have information relating to my professional and ethical qualifications, competence, character and personality.

I consent to the inspection by ActivHealthCare or its designated representative for ActivHealthCare beneficiaries of all records regarding beneficiaries, including institutions and health care organizations with which I am or have been associated which may contain information related to my professional and ethical qualifications, competence, character and personality.

I release from liability all individuals, corporations and organizations which provide information to ActivHealthCare in good faith, including medical and otherwise privileged or confidential information.

I release ActivHealthCare, its chiropractic administrators, management agents, directors, and staff from liability for acts performed in good faith in connection with the evaluation and investigation of information and materials I have authorized them to request and inspect.

I release ActivHealthCare, its administrators, staff, directors and management agents from liability for disclosing information obtained in the course of their efforts to evaluate and/or investigate my qualifications and from liability for responding in good faith to inquiries from persons or entities to whom I may submit applications for employment and privileges in the future. I agree that photocopies of this signed authorization will be acceptable as an original signature.

I understand that ActivHealthCare will rely upon the information given on this document during the evaluation of my credentials to determine compliance with network credentialing standards.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ GA License # \_\_\_\_\_