

**MEDICAL NETWORK, INC.  
Release and Attestation**

**Provider Name:** \_\_\_\_\_ **Group Name:** \_\_\_\_\_  
**Payment Name:** \_\_\_\_\_ **UPIN#:** \_\_\_\_\_

**GENERAL RELEASE OF INFORMATION**

In order for Medical Network, Inc. ("MedNet") and any other designated entity that is involved with MedNet in the credentialing process ("Designated Credentialing Organization") to conduct a review of any and all information relevant to the credentialing or recredentialing of my participation, I hereby CONSENT to the inspection of any and all pertinent records needed by MedNet and the Designated Credentialing Organization to complete its credentialing or recredentialing process and to communicate with any individual(s) including physicians, attorneys and claims investigators as well as hospitals, nursing homes or insurance companies having information which will assist with the credentialing process and to a personal interview, if requested.

I hereby RELEASE from any liability all individuals and organizations who provide information to MedNet and the Designated Credentialing Organization, its employees and/or its agents, and/or a designated medical credentials verification service in good faith and without malice concerning my competence, character, and any other qualifications, including otherwise privileged or confidential information associated with any information necessary to complete the credentialing or recredentialing process. MedNet and the Designated Credentialing Organization agree that all information provided pursuant to this consent and release will be held in confidence by MedNet and the Designated Credentialing Organization and will be used by MedNet and the Designated Credentialing Organization in connection with determination of whether to enter into or continue a provider relationship with a clinician, or to provide information or written references to hospitals or health care facilities for the purpose of being credentialed by these hospitals or health care facilities, or for any other purpose required by law.

I also consent to the release from any liability all individuals and organizations, including MedNet and the Designated Credentialing Organization, its employees and/or agents, and/or a designated medical credentials verification service who either provide, review, or act upon the above referenced information. Additionally, I RELEASE from liability all those individuals who provide information or written references to hospitals or health care facilities for the purpose of being credentialed by these hospitals or health care facilities, or for any other purpose required by law.

I fully understand that this authorization and release extends for a period of two years, which covers the length of time from now to my next recredentialing with MedNet. This authorization and release is extended for this period in order to allow MedNet and / or agents to update its data, to conduct office visits and medical records reviews and to gather such information and materials as MedNet and / or agents deem necessary to keep my credentialing files current and to conform with NCQA standards. I maintain the right at any time to revoke this authorization and release by notifying MedNet in writing of my revocation.

I hereby agree to maintain my professional liability coverage in amounts equal to or greater than MedNet's minimum requirements, currently \$1,000,000 and \$3,000,000, for the duration of my affiliation with MedNet.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ATTESTATION**

I hereby certify under the pains and penalties of perjury that all information contained within my application and recredentialing materials currently on file with Medical Network, Inc., if any, is true and complete.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_