

MEDICAL NETWORK, INC.
Release and Attestation

Provider Name: _____ UPIN#: _____

Group Name(s): _____

GENERAL RELEASE OF INFORMATION

In order for Medical Network, Inc. ("MedNet") and Aperture Credentialing, Inc, a National Committee on Quality Assurance [NCQA] certified Credentials Verification Organization, and any other designated entity that is involved with MedNet in the credentialing process (collectively referred to as "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 Designated Credentialing Organization to complete the 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 Designated Credentialing Organization, their employees and/or their agents, 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. I release and agree to hold harmless MedNet and Designated Credentialing Organization, and their respective officers, directors, representative, employees and agents from any and all liability for any damages, costs and expenses which may result from the gathering or good faith use of the information gathered during the credentialing process. MedNet agrees that all information provided pursuant to this consent and release will be held in confidence by MedNet and will be used by MedNet 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. Further, Designated Credentialing Organization agrees to use this information in the normal course of its business to provide primary source verification and provider data management services, excluding any release of information to third parties for the purposes of solicitation.

I also CONSENT to the release from any liability all individuals and organizations, including MedNet and Designated Credentialing Organization, their employees and/or agents, 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 three 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 their 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 by certified mail of my revocation.

I understand that with the exception of information determined by MedNet to be peer review protected, I have the right to request in writing and subsequently review, and request correction of, any information obtained by MedNet or its Designated Credentialing Organization to support the evaluation of my credentialing application.

I hereby agree to maintain my professional liability coverage in amounts equal to or greater than MedNet's minimum requirements, currently \$1,000,000/\$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 submitted in connection with my application for credentialing or recredentialing is complete and accurate.

Signature: _____ Date: _____