Authorization to Release Information

I, the undersigned, applicant, am applying for priveleges at the Maricopa County Health Care for the Homeless program. All information provided or in connection with my Health Care for the Homeless application is true and correct to the best of my knowledge and belief. As part of the credentialling and priveleging process, I am authorizing Health Care for the Homeless Medical Director to verify the information provided for the sole purpose of credentialling and priveleging.

This information may include, but is not limited to, information about me supplied by the National Practitioner Data Bank; any applicable state licensing board; the Drug Enforcement Agency; national certification boards; institutions of higher learning which I have attended.; any mal[practice carrier; any hospital, health maintenance organization or other health care facility where I have practiced, and any other person or organization having knowledge of my professional qualifications or credentials. The information to be provided hereunder includes, without limitation, favorable or unfavorable information, including any state or hospital disciplinary actions or proceedings, medical malpractice coverage and claims, suits and settlements, licensing and certification information, Drug Enforcement Agency registration, medical or nursing training, hospital affiliations, performance records, quality assurance data or other related confidential information_

I hereby release each person or organization described above from and against any or all liability caused by or related to any good faith communication of information pursuant to this authorization.

This authorization shall remain valid a slong as I maintain a professional relationship with Maricopa County Health Care for the Homeless, and any party furnishing information pursuant to this authorization is entitled to rely on the representation of Maricopa County Health Care for the Homelessor its designees that this authorization is currectly valid. A photocopy of theis authorization is as valid as the original.

______________________________ ______________________

Practitioner Name Social Security Number

______________________________ ______________________

Practitioner Signature Date Signed

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Medical Director Maricopa County Health Care for the Homeless	Date