AHP Authorization for Release of Information

I hereby authorize Accountable Health Partners, LLC and Accountable Health Partners-IPA, LLC (collectively "AHP") and its representatives to obtain the following information and consult with the following entities and/or persons who may have information relative to my professional practice.

- administrators and members of medical staffs of hospitals, facilities, third party insurers, managed care organizations, professional associations, medical schools and other training institutions, and/or other organizations with which I have been associated;
- past and present malpractice carriers;
- all records and documents, including medical records, at hospitals or health care facilities, that may be material to an evaluation of my professional qualifications and competence to be a participating physician in AHP; and
- any state Departments of Education or Health, the National Practitioner Data Bank and other persons or references on request provided the request for information is done in good faith and without malice.

By my consent, I agree to hold AHP and its representatives free of any and all liability for their actions, performed in good faith and without malice, in connection with evaluating my application, credentials, and qualifications to be a participating physician in AHP.

I hereby release from any liability all those who, in good faith, review, act on, or provide information regarding my competence, training, experience, professional ethics, character, health status and other qualifications for participation in AHP.

I hereby authorize and consent to the release of information by AHP and its representatives to hospitals, medical associations, the New York State Department of Education, the New York State Department of Health, regulatory accrediting agencies, third party users, and managed care organizations. This request for information can be released by AHP as long as such release is done in good faith and without malice.

I understand and agree that I, as an applicant to be a participating physician in AHP, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications. I understand that my failure to provide any requested information will cause my application to be incomplete and will prevent it from being processed further.

I attest under penalty of perjury that all the information contained in my application to AHP is complete and accurate. I understand that any misstatement or omission from this application, whether intentional or not, whether discovered prior to or after participation in the AHP is granted, may result in the denial or immediate termination of such participation.

I agree to notify AHP immediately of any material change to the information reported on my application, including but not limited to changes in status at other organizations; restrictions to any license; restriction of any privileges; commencement of a formal investigation by any health care facility or regulatory agency; or changes in physical or mental health.

I have read and understand this AHP Authorization for Release of Information form. A facsimile or copy of this form shall be as effective as the original when so presented. This AHP Authorization for Release of Information form shall remain in full force and effect for a period of two (2) years from the date shown below.

Signature: _____ Date: _____

Please print your name: _____