



## AUTHORIZATION FOR RELEASE OF INFORMATION

I have requested to become a participating provider in **ehp**, a preferred provider product line offered by **Significa Benefit Services (Significa)**. By my signature below, I hereby:

- 1) Authorize **Significa** to consult with members of the medical staff and administration at hospitals with which I am and have been associated, and with other individuals who may have information bearing on my character, professional and ethical qualifications; **and,**
- 2) Consent to release to **Significa** said information, documents, and records that may be material to the evaluation of my professional qualifications and competence, as well as to the investigation of my moral and ethical qualifications; **and,**
- 3) Authorize and consent that such information, documents and records may be released to **Significa** or its representatives. All information, documents and records released to **Significa** shall be considered and maintained as confidential and privileged to the extent permitted by law; **and,**
- 4) Agree to hold harmless **Significa**, its employees and authorized representatives, and any third parties from any liability under civil or statutory laws relating to the release of said information to **Significa** that is provided in good faith and without malice; **and,**
- 5) Waive any right or privilege I may have with respect to any information collected by **Significa** pursuant to this authorization; **and,**
- 6) Waive any rights or privileges I may have with respect to such information in the event that **Significa** is required to produce such information to any person or entity with appropriate authority to receive such information, including but not limited to subpoenas, Court orders, or similar requests; **and,**
- 7) Agree this authorization shall be attached to and become a part of my application for credentialing. I further agree my signature on this form and/or the application when communicated by facsimile transmission or as a scanned document sent via email shall be binding if transmitted in either fashion with electronically reproduced signatures treated as original.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Applicant

\_\_\_\_\_  
Name of Practice

Please return this form and requested materials by mail to:

Manager of Credentialing

**Significa Benefit Services**

PO Box 8737

Lancaster, PA 17604-8737

Or by fax to 717-399-1693 or email to [providerrelations@ehpservices.com](mailto:providerrelations@ehpservices.com)