

**HEALTH PARTNERS OF KANSAS
STATEMENT OF
ATTESTATION, AUTHORIZATION AND RELEASE**

I, the undersigned, agree to abide by the rules, regulation, policies and procedures of Health Partners of Kansas and those of its affiliates that have networks of health services providers to which I am applying.

I understand that any misstatements and/or omissions from this application for credentialing shall constitute grounds for denial of credentials or as grounds for a professional review. I do not presently have a medical or mental health condition that impairs my ability to perform all the essential functions and responsibilities, with or without accommodation, required for the practice in which I am seeking to become a participating provider, and do not presently have a condition that poses a direct threat to the health and safety of myself, my patients or others. All information submitted by me in this application is correct and complete to the best of my knowledge and belief.

I understand that my application will be treated with confidentiality and will be evaluated in a nondiscriminatory manner. I further understand that I have the right to review and correct any erroneous information used to evaluate my application during the credentialing process.

I consent to and authorize Health Partners of Kansas and its affiliates, their employees, agents, and representatives, at any time during the evaluation of my qualifications, credentials, clinical competence, character, ethics, behavior, or any other matter related to my application and initial and continuing qualifications for membership from and consult with the employees, agents and representatives of hospitals, health care facilities, institutions, managed care organizations, or employees with which I have been or may be associated with; insurance companies from which professional liability insurance has been or may be purchased by me or on my behalf; professional societies, licensing boards or agencies; and any other persons or entities who may have relevant information.

I consent to and release Health Partners of Kansas and any of its affiliates, and their employees, agents representatives from liability for the release of information to hospitals, health care facilities, institutions, managed care organizations, organizations of health professionals, licensing boards and agencies, and insurance companies in response to any inquiries concerning me provided that such release of information is done in good faith and without malice based on a reasonable belief that the information is true. Copies of all such written correspondence shall be made available to me upon request.

I UNDERSTAND AND AGREE TO ALL TERMS AND CONDITIONS SET FORTH ABOVE, REGARDLESS OF WHETHER I AM APPROVED FOR CREDENTIALING. A PHOTOCOPY OF THIS DOCUMENT SHALL BE AS BINDING AS THE ORIGINAL.

Applicant's Signature

Date

Type or Print Name

Date of Birth

Alias or Maiden Name Used

Social Security Number