Please sign this Affirmation & Release and return in with your CAQH to:

Transparent Health Network
630 Fairview Rd. Ste. 201
Swarthmore, PA 19081-2335
phone: (877) 297-8864
fax: (888) 965-2082
www.TransparentHealthGroup.com/Provider
Providers@TransparentHG.com

Affirmation and Release

I hereby authorize and consent to the release of information by any hospital or hospital's medical staff, medical associations, National Practitioner Data Bank, New York State Department of Social Services, New York State Department of Health, other government agencies, malpractice insurance carriers and previous and present and other interested parties regarding information concerning me. I hereby release Transparent Health Group, LLC, well as the institution(s) or organizations providing such information and their staff, from any and all liability for the obtaining and release of such information. I also understand that I have a continuing obligation to amend and update my answers.

By my signature, I hereby attest that the information in this application is complete and accurate and I agree to provide information as required to support this application. The undersigned hereby certifies that the above information requested is truthful, correct and complete in all respects. The undersigned further understands that the submission of false and/or significantly misleading information or the withholding of relevant information is grounds for termination of THG's Provider Agreement.

APPLICANT SIGNATURE

PRINT NAME	GENDER Male ☐ Female ☐	DATE SIGNED