Authorization and Release of Information
To Designated Contacts

I hereby consent to, authorize, and release from liability CAQH, its agents, and CAQH affiliated vendors to release access to my application data, as it relates to the completion and maintenance of the provider credentialing data contained therein, as long as this information is provided in good faith and without malice, unless such acts are due to the gross negligence or willful misconduct of CAQH, its agents, and any CAQH affiliated vendors, to:

1. **Giovanna Alarcon** (Primary Authorized Contact Name) of **Community Health Center Network** (Primary Authorized Contact Organization/Practice Name), who may be reached at **510-297-0271** (Primary Authorized Contact Information).

and/or

2. (Secondary Authorized Contact Name) of **Community Health Center Network** (Secondary Authorized Contact Organization/Practice Name), who may be reached at **510-** (Secondary Authorized Contact Information).

Of the information to be released, to the delegated authorized party (or parties) as specified above, includes my CAQH Provider ID number, CAQH ProView Username, and Primary Method of Contact.

I understand that a photocopy or facsimile of this Authorization and Release form shall be as effective as the original when so presented, unless canceled by me in writing.

Printed Name of Provider

CAQH ID Number

Signature of Provider

Date of Signature

Expiration of Authorization

Valid for up to 3 years

(Providers please note, if an expiration date is not included, you letter will expire three years from the date the letter was received by CAQH.)