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, Provider Network Specialist** of **Community Health Center Network**, who may be reached at **510-297-0271.**

and/or

2. **Irene Chongchareun, Provider Services Coordinator of Community Health Center Network, who may be reached at 510-297-0401.**

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: _____**

Username: _____ **Password: _____**

_____

Signature of Provider **Date of Signature: _____**

Expiration of Authorization:

Auto renewed unless its cancel/term by either party to manage the CAQH account.