EMI HEALTH™ Smart Benefits

emihealth.com

852 EAST ARROWHEAD LANE
MURRAY, UTAH 84107-5298
TOLL FREE 800 662 5850
CORPORATE 801 262 7476
FAX 801 270 3016

PROVIDER RELEASE OF INFORMATION AND AUTHORIZATION FORM

I acknowledge and agree that EMI Health has a valid interest in obtaining and verifying information concerning my professional competence. Therefore; in connection with any application I have in the past, am making at this time, or will make in the future.

1. I authorize EMI Health and any persons acting on its behalf to consult with hospital administrators, providers, malpractice insurance carriers and other persons and entities to obtain and verify information concerning my professional competence, character, and moral and ethical qualifications. I release EMI Health and its employees, managers, agents and consulting committees from any and all liability for their acts performed in good faith and without malice in obtaining, verifying and evaluation such information. I consent to and authorize EMI Health and all persons acting on its behalf to review relevant information in the medical records I have completed to ensure compliance with EMI Health quality assurance.

2. I consent to and authorize the release by any person or entity to EMI Health of all information and documentation that my be relevant to an evaluation of my professional competence, character, morality or ethical qualification, including any information and documents relating to any disciplinary action, clinical proceeding, professional incompetence, suspension or curtailment of medical or surgical privileges (including malpractice claims and/or coverage and chemical or alcohol dependency). I hereby release any such person or entity providing such information from any and all liability for doing so.

3. I understand that I have the burden and legal responsibility of providing adequate information to EMI Health to demonstrate my professional competence, character, moral and ethical qualifications.

4. I may revoke this release of information and authorization by providing EMI Health five (5) working days prior written notice of revocation.

If any material changes occur affecting my professional and/or malpractice insurance status I agree to notify EMI Health in writing within thirty (30) days of such change.

_____ _____

Name of Provider (please print) Provider NPI #

_____ _____

Signature of Provider Date