



**TRI STATE CHILD HEALTH SERVICES, INC.  
3333 Burnet Avenue  
Cincinnati, Ohio 45229-3039**

***Consent and Release***

I certify and attest to Tri State Child Health Services (PHO) that all information contained in the foregoing application is true, correct and complete. I acknowledge that I have read the enclosed information and agree to be bound by their terms and all membership criteria, standards and policies of the PHO. I also agree that membership in the provider panel of the PHO is at the sole discretion of the PHO Board of Trustees and such decisions are considered final.

I authorize the PHO, its contracted parties or affiliated organizations, or any successors, employees, agents, officers or Board members to consult/query hospitals, the National Practitioner Data Bank, state medical boards and societies, criminal background checks and other persons or entities to obtain information concerning my qualifications, including without limitation my professional competence and conduct. I consent to the release to the PHO of any and all information that may be relevant to an evaluation of my qualifications, including information about disciplinary actions and information that might otherwise be considered confidential or privileged. I consent to the release to the PHO of any and all payor utilization, claims, quality, and patient/family satisfaction or complaint data related to me or my practice.

I release the PHO and any and all persons or entities providing information about me to the PHO from any and all liability connected with or arising from the release of such information, provided that such parties acted in good faith and without malice. I also release the PHO and its contracted parties, employees, agents, officers, and Board/Committee members from any and all liability connected with decisions regarding my application or membership status, provided that such parties acted in good faith and without malice.

I authorize the PHO and its contracted parties to provide credentialing/recredentialing-related information to payors and accreditation/regulatory agencies, as required, and release the PHO and its contracted parties from any and all liability connected with or arising from the release of such information, provided that such parties acted in good faith and without malice.

I authorize the PHO to conduct office site evaluations and medical record reviews at the time of, but not limited to, initial credentialing and recredentialing.

I agree to appear for interviews in regard to the application, if necessary. I understand that I have the burden of providing adequate information to the PHO to demonstrate my qualifications. I understand and agree that any misstatement or material omission in this

application will constitute grounds for rejection of my application or dismissal as a provider in the PHO. I understand that I may review the information which I submitted with my application and request that erroneous information be corrected and/or supply additional clarification, if necessary. If any material changes occur in the information I have provided in this application making such information no longer correct and complete or affecting my professional status, I understand and agree that it is my obligation to notify the PHO within ten (10) days of said occurrence. Failure to comply with this obligation may constitute grounds for rejection of my application or dismissal as a provider in the PHO.

This document shall remain in force for a period of twenty-four (24) months at which time I will be asked to resign the form. If this consent and release form is revoked or expires, the terms and conditions shall remain in effect as to actions previously taken under the then existing terms of this release.

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name