Authorization and Release

CCVS ORGANIZATION-SPECIFIC

I hereby authorize the Arkansas State Medical Board to provide my credentialing information gathered by the Board to CareSource (a Credentialing Organization) with whom I am affiliating and seeking privileges.

This Authorization shall remain in effect for a period not to exceed two (2) years unless revoked by me in writing.

I understand that if I have provided this organization with permission to utilize my electronic signature for the purpose of obtaining my credentialing information from the Arkansas State Medical Board's CCVS, this is the legal equivalent of my signature on this form and is as valid as if I signed the form with pen and ink and it can be enforced in the same way.

Typed or Printed Name of Physician: ______________________________

Licensure Number: ______________________________

****Signature of Physician:** ______________________ Date Signed: __________
(Stamped signature is not acceptable, Electronic signatures only acceptable if signed on this form.) Mo/Day/Year

*This document does not authorize the Arkansas State Medical Board to release information collected to third parties except as later authorized by the above physicians and Arkansas law.

***In no event shall the practitioner or healthcare organization utilizing the electronic signature hold the employees of the Arkansas State Medical Board and CCVS responsible or liable, either personally or in their official capacity, directly or indirectly, for any damage or loss caused or alleged to be caused by or in connection with the use of or reliance on the practitioner's electronic signature in providing the credentialing information requested to the credentialing organization identified on this document. This statement will serve as an attestation that the practitioner's electronic signature affixed to this Organization Authorization and Release is true and correct and represents the practitioner's true signature.*

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