AUTHORIZATION AND RELEASE

I hereby authorize the Arkansas State Medical Board to provide my credentialing information gathered by the Board to ____
(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.

Typed or Printed Name of Physician: ____

Licensure Number: ____

Signature of Physician: ______________________________ Date Signed: ____________
(Stamped signature is not acceptable)

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