MIDWEST PHYSICIAN
ANESTHESIA SERVICES, INC.

Disclosure and Authorization for Use of Signature

I, _____, hereby authorize the use of my signature for credentialing paperwork. This authorization includes but is not limited to, the release of my professional credentials, qualifications, and any other necessary documentation required for the credentialing process.

I understand that this authorization is necessary to facilitate the verification of my credentials by the relevant entities, including healthcare organizations, insurance companies, and regulatory bodies. I acknowledge that the information obtained through this process will be used solely for credentialing purposes and will be kept confidential under applicable laws and regulations.

By signing below, I consent to the use of my signature for the purposes and confirm that all the information provided is accurate and complete to the best of my knowledge.

Printed Name: _____

Signature:

Date: _____