ATTESTATION FORM

I, _____, hereby attest that I am a provider with _____ ("Provider Participant"). I further attest that my signature below signifies my agreement to be bound by and comply with all the terms of the Health information Exchange Provider Participation Agreement, the Terms and Conditions for Health Information Exchange Organization Provider Participation Agreement, and Central Coast Health Connect Security & Privacy Policy and Procedure Manual.

Provider Name: _____

Signature: _____

Date: _____