

## 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: \_\_\_\_\_