

**ACKNOWLEDGMENT REGARDING PROVIDER
CREDENTIALING INFORMATION**

I _____, hereby acknowledge

(name of medical provider and title)

and understand that any and all information regarding my professional credentials ("Credentialing Information") provided to or collected by the State of Connecticut Judicial Branch (including information collected by the Council for Affordable Quality Healthcare ("CAQH") through its Universal Provider Database ("UPD"), is subject to the Connecticut Freedom of Information Act ("FOIA"), Chapter 14 of the Connecticut General Statutes, as said FOIA may be amended from time to time. While many elements of my information that is submitted through the UPD may be subject to exceptions from disclosure under the FOIA, disclosure of certain of the information I submit may be required under the FOIA. I further acknowledge and understand that any consent or authorization that I may give regarding the collection, disclosure and/or use of my Credentialing Information through the UPD will be subject to, and be deemed to incorporate, this Acknowledgment. In connection with any request for Credentialing Information directed to the Judicial Branch pursuant to the FOIA, the Judicial Branch will (1) notify the medical provider of any such request within a reasonable time after receipt, and (2) determine in good faith whether there is a colorable legal basis (pursuant to an exception to the FOIA or otherwise) for withholding from disclosure Credentialing Information that is the subject of such a request; provided, however, that the determination of whether there exists a colorable legal basis for withholding Credentialing Information from disclosure shall be made at the sole discretion of the Judicial Branch, and further provided that nothing in this Acknowledgment shall be construed as preventing the Judicial Branch from complying with a valid court or administrative order (including without limitation orders entered by the Connecticut Freedom of Information Commission) entered in connection with such a request.

(Signature of medical provider)

(Date)