

**BIDCO IT ACCESS REQUEST ATTESTATION**

I attest that the below referenced person is employed or supervised by me. I acknowledge this employee may obtain confidential and privileged information which will not be shared outside of my practice and billing company. I further agree to notify BIDCO in the event this employee leaves my practice.

Date: \_\_\_\_\_

Employee: \_\_\_\_\_  
(Please print)

Supervising Physician: \_\_\_\_\_  
(Please print)

Supervising Physician Signature: \_\_\_\_\_