AUTHORIZATION TO RELEASE CONFIDENTIAL MALPRACTICE INSURANCE AND CLAIM HISTORY INFORMATION

Authorization to Release:

To obtain a verification of medical professional liability insurance and/or claim history, please complete the information as requested below**.** Once completed, return form to:

Risk_Insurance@beaumont.org or Fax (947)522-1056

I request and authorize any coverage information and claim history released by my current or prior carriers for:

Insurance Program: _____ _____ _____ _____
BH Employed BPIC OAC OTHER

Policy Number(s): _____

Insurance Verification Only: **Yes** _____ **No**_____

If needed, number of Years for Claim History: _____ _____
5 Year 10 Year

Practitioner's Name (print):_____

Address:_____

City / State / Zip:_____

Birthdate (month/day):_____**Specialty:**_____

Phone Number:_____ **Fax Number:**_____

THIS INFORMATION IS TO BE RELEASED TO:

Name:_____

Address:_____

City / State / Zip:_____

Phone Number:_____ **Fax Number:**_____

My signature below authorizes the release of this information. I agree to hold the company harmless from any liability arising out of the release of the information.

_____ _____
Signature of Insured ***Date***