## AUTHORIZATION TO RELEASE CONFIDENTIAL MALPRACTICE INSURANCE AND CLAIM HISTORY INFORMATION

## **Authorization to Release:**

Signature of Insured (original signature required)

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:

## Insurance\_Risk@corewellhealth.org or Fax (947)522-1056

I request and authorize a	any coverage informat	ion and claim history relea	ased by my current of	or prior carriers	for:
Insurance Program:	CHE Employed	CHW/CHS Employed	BPIC/CHPIC	OAC	OTHER
<b>Policy Number(s):</b>				-	
Select One:					
Insurance V	erification Only:				
Insurance V	erification with Clain	m History:5 Year	<b>or</b> 10 Ye		
Practitioner's Name (p	orint):				_
Address:					
City / State / Zip:					_
Birthdate (month/day)	:Spe	cialty:	Degree:		_
Phone Number:		Fax Number:			
THIS INFORMATIO	N IS TO BE RELEA	ASED TO:			
Name:					
Address:					
City / State / Zip:					
Phone Number:		Fax Number:			
E-mail:					
My signature below authorising out of the release		this information. I agree to	o hold the company	harmless from a	ny liability

Date