



ProAssurance Group

800/284-7424
Fax 317/658-2589
www.ProAssurance.com

**CONFIDENTIALITY AGREEMENT,
AUTHORIZATION, AND RELEASE FORM TO PROCESS CLAIM HISTORY**

INSURED or POLICY HOLDER: _____ POLICY #: _____

SOCIAL SECURITY or TAX ID #: _____

INSURED or POLICY HOLDER
CURRENT ADDRESS: _____

ADDRESS FOR DELIVERY OF
REQUESTED INFORMATION
IF DIFFERENT THAN ABOVE: _____

ProAssurance is or was the carrier of my medical professional liability insurance, and as such ProAssurance maintains certain information regarding my medical practice and, specifically, the history of any malpractice claims against me. I understand that this information is extremely sensitive and confidential and may be protected by attorney-client privilege.

I am requesting that certain information from ProAssurance be provided concerning my claims history, I authorize ProAssurance to release information relating to claims and suit against me which is on record with ProAssurance. I understand that the information to be provided is highly confidential and should not be disclosed in any manner that would cause such information to benefit any claimant.

As a result, my representative and I agree to maintain this information as confidential. This information will only be disclosed in the course of procuring insurance coverage or as a part of credentialing by health care providers and insurers. Prior to any such disclosure, I will cause any such entities to agree not to disclose the information to any party. If requested or required to disclose the information in a legal proceeding, my representatives and I will immediately notify ProAssurance in writing so that ProAssurance may determine the appropriateness of contesting such disclosure.

I understand that neither ProAssurance nor its representatives makes any representation or warranty as to the accuracy or completeness of the information and agree that they shall have no liability with respect to the information or its use.

I agree that money damages alone will not be sufficient remedy for any breach of the confidentiality of this information other than as stated herein either by me or my representatives, and, in addition to all other remedies, ProAssurance shall be entitled to specific performance and injunctive or other equitable relief.

SIGNATURE of Insured or Policyholder Representative

DATE: _____

PRINTED NAME of Insured or Policyholder Representative

FAX TO: ProAssurance
ATTN: Michelle McClory
FAX #: (317) 558-2563