

**AUTHORIZATION TO RELEASE SPECIFIC CONFIDENTIAL
CLAIMS INFORMATION**

I hereby request and do authorize _____ to release the following information regarding all Professional Liability claims made against me while I was insured under the below captioned policy.

- Insurance policy number
- Date of alleged negligence
- Whether pending or closed
- If pending, the reserve amount
- If closed, the amount of any indemnity paid
- Other general information as requested

The organization to whom, said information is to be released to:

**Healthcare Professional Services, Inc.
313 Swanson Drive
Lawrenceville, GA 30043
Phone: (678) 935-5040 Fax: (678) 935-5032**

Its designated agents, employees or representatives. I agree to indemnify and hold Healthcare Professional Service, Inc. harmless from any liability, expense or claims arising out of the release of this information.

Date Signed

Insured Signature

Policy Number

Named Insured