



ProAssurance Corporation

205/877-4400
800/282-6242
Fax 205/802-4799

www.ProAssurance.com

**CONFIDENTIALITY AGREEMENT, AUTHORIZATION, AND RELEASE FORM FOR
DETAILED CLAIM HISTORY**

INSURED or POLICYHOLDER: _____ POLICY # _____

SOCIAL SECURITY OR TAX IDENTIFICATION # _____

INSURED'S CURRENT ADDRESS: _____

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

ProAssurance Corporation and its affiliates, The Medical Assurance Company, Inc.; Medical Assurance of West Virginia, Inc.; ProNational Insurance Company; and Red Mountain Casualty Insurance Company, Inc., are hereinafter referred to collectively as "The Company".

The Company is or was the carrier of my professional liability insurance, and as such The Company maintains certain information regarding my 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 The Company be provided concerning my claims history. I authorize The Company to release information relating to claims and suits against me which is on record with The Company. 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 representatives and I agree to maintain this information as confidential. The 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 The Company in writing so that The Company may determine the appropriateness of contesting such disclosure.

I understand that neither The Company 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, The Company 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