Fax#: 608.828.1136
Email: claimshistory@proassurance.com

CONFIDENTIALITY AGREEMENT, AUTHORIZATION, AND RELEASE FORM FOR:
(Place a check in the box next to the report type being requested)

☐ **CLAIM HISTORY – CREDENTIALING (Examples: Privileges, Licensing)**

☐ **LOSS RUN (Examples: Evaluate Frequency, Risks, Deductibles)**

INSURED or POLICYHOLDER:_____POLICY #(S) _____

SOCIAL SECURITY OR TAX IDENTIFICATION #_____

INSURED'S CURRENT INFORMATION:
(Street, City, State, Zip, Fax #, E-mail) _____
_____
_____

(If report is to be delivered to a person, location, or number different than listed above, this section must be filled out) _____
_____
_____

ProAssurance Corporation and its affiliates, The Medical Assurance Company, Inc.; Woodbrook Casualty Insurance, Inc.; ProNational Insurance Company; ProAssurance National Capital Insurance Company, Inc.; Physicians Insurance Company of Wisconsin, Inc.; Red Mountain Casualty Insurance Company, Inc.; and Georgia Lawyers 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, including 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 hereby request the release of certain information 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.

My representatives and I agree to maintain this information as confidential. I represent and warrant that the information will be disclosed to third parties only 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 other 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, including reasonable attorney fees incurred by The Company in enforcing its rights under this agreement.

_____ DATE:_____
SIGNATURE of Insured or Policyholder Representative (must be signed and dated within 365 days of request)

_____
PRINTED NAME of Insured or Policyholder Representative, & Title

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Form approved/updated 04/30/09