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PROASSURANCE
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Confidentiality Agreement, Authorization, and Release Form for Loss Run

Loss Run (Examples: Evaluate Frequency, Risks, Deductibles) This report includes the following file types (open, reopened, and closed): First Notice, Incident, Legal Defense, Med-Pay, Claim, Pre-Suit, Suit.

Insured or Policyholder:_____ **Policy #(s):** _____

Social Security, DOB or Tax Identification #: _____
To help identify the correct Insured or Policyholder

Insured's Current Information: _____
(Street, City, State, ZIP, Fax #, Email) _____
_____

If report is to be delivered to a person, location, or number different from that listed above, place the recipient's information here.
Name: _____
Address: _____
Fax/E-Mail: _____

Note: We can send to a third party only if form is signed by the Insured and the Policy/Insured is canceled.

I have or had professional liability insurance with one or more of the ProAssurance Companies (ProAssurance Indemnity Company, Inc.; ProAssurance Casualty Company; ProAssurance American Mutual, a Risk Retention Group; and ProAssurance Specialty Insurance Company, Inc.). (Any such companies are hereinafter referred to collectively as the "Company.") 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 and state and federal law.

I hereby request the release of certain information concerning my claims history. I authorize the Company to release any information relating to claims and suits against me that 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 make 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 a sufficient remedy for any breach of the confidentiality of this information (other than as stated herein) either by me or by 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, & Title (must be signed and dated within 365 days of request)

_____

PRINTED NAME of Insured or *Policyholder Representative, & Title

*Must be an approved, documented representative of the Policy

Fax: 205.868.4073
Email: Credentialing@ProAssurance.com

Web Form approved/updated 3/2019