crico

Release of Information Request Form

This form must be completed and returned to CRICO Underwriting before CRICO Insurance documents will be issued.

Clinician Information

Name:	
Title:	
Primary Employer:	

SIGNATURES (Release of Information and Attestation)

Note: Clinician's signature is required following this Release of Information statement.

I, Clinician, hereby authorize Controlled Risk Insurance Company of Vermont, Inc. (A Risk Retention Group) ("CRICO Vermont"), Controlled Risk Insurance Company, Ltd. ("CRICO Ltd."), and The Risk Management Foundation of the Harvard Medical Institutions Incorporated ("RMF," and together with CRICO Vermont and CRICO Ltd., "CRICO") to release full information to ____ with respect to me or my medical professional liability coverage and/or claims history, including, but not limited to, any claim or suit or incident pertaining to professional acts or omissions asserted against me and/or my business entity. This information may include the name of the claimant(s), nature and date of claim(s), amounts paid, if any, and other disposition or information in CRICO's possession, custody or control on my current policy, number, and/or any other policy I have had, as well as the dates of policy coverage. If proof of insurance is being requested with this release, I understand it will not disclose claim related activity. I expressly release and discharge from liability CRICO, and all persons associated with CRICO who provide information pursuant to this release. I further authorize that a photocopy of this release be accepted with the same authority as the original.

The information I have provided is complete and accurate.

This authorization expires 30 days from the date signed unless another date is specified here: ____________

____ Personal Signature of Clinician

____________________________ Date Signed