AUTHORIZATION FOR RELEASE
LIABILITY INSURANCE / MALPRACTICE INFORMATION

I authorize the release of my liability insurance information and medical malpractice history to the following:

Name of recipient: _____
Organization: _____
Address: _____
Phone: _____
Fax: _____
Email: _____

Signed:

_____ _____
Print Your Name Here, Sign Above Date

Email completed form to: medcred@umn.edu