



ProNational Insurance Company
(800) 292-1036
Fax: (517) 347-6321
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: _____

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

I understand that neither ProNational Insurance 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, ProNational Insurance Company shall be entitled to specific performance and injunctive or other equitable relief.

Signature of Insured or Policyholder Representative

Date: _____

**Fax To: ProNational Insurance Company
Attn: Claims Department
(517) 347-6321**

Printed Name of Insured or Policyholder Representative