

**AUTHORIZATION
TO OBTAIN PROFESSIONAL LIABILITY
CLAIMS HISTORY REPORT**

I hereby authorize Medical Mutual Insurance Company of Maine to release information relating to my professional insurance coverage and professional liability claims history to:

Agent or Organization _____

Address: _____

By signing this authorization, I freely consent to the release of this specified information to the above-named agent or organization and, further, I release Medical Mutual Insurance Company of Maine and its employees from liability in providing the requested information for the entire time this authorization is in effect.

I understand this authorization will be in effect for one calendar year from the date signed. If at any time during that one-year period of time I wish to revoke this authorization, I will be responsible for sending a revocation in writing to both the agent or organization named above and to Medical Mutual Insurance Company of Maine.

The completed form may either be emailed to credentialing@medicalmutual.com or uploaded at <https://www.medicalmutual.com>.

Insured Name (please print): _____

Insured Signature: _____

Date: _____