MedicalMutual
INSURANCE COMPANY OF MAINE
One City Center P.O. Box 15275 Portland, Maine 04112-5275

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:

_____
(Organization name)

_____
(Address line 1)

_____
(Address line 2)

_____
(City, state zip code)

_____
(Email address of recipient)

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/messages/compose for the "Coverage Verification" department.

_____ _____
(Insured name) (Policy number(s))

_____ _____
(Insured signature) (Date)