KAMMCO

AUTHORIZATION & RELEASE OF INFORMATION

I consent to and authorize KAMMCO and any of its affiliates and their employees, agents, and representatives to release information concerning medical professional liability claims that arose while insured by KAMMCO.

I consent to and authorize and release KAMMCO and any of its affiliates, and their employees, agents and representatives from liability for the release of information in response to any inquiries concerning me, provided that such release of information is done in good faith and without malice based on a reasonable belief the information is true. Copies of all such written correspondence shall be made available to me upon request.

I hereby agree to all terms and conditions set forth above. A photocopy of this document shall be as binding as the original.

Applicant Signature **Date**

Applicant Name (Type or Print)

Please sign, scan, & email the completed form to
lossrun@kammco.com, along with your request.