CLAIM HISTORY/ CONFIDENTIALITY AGREEMENT, AUTHORIZATION, AND RELEASE FORM

Insured or Policyholder: ____

Social Security or Tax ID #: __________________ Policy #: _____________

Insured or Policyholder Current Address: ____
____
____

Address for delivery of requested information if different than above:

MacLennan & Bain Insurance
214 Aberdeen Drive
Valparaiso IN 46385
Fax: 219-464-9826

Indiana Residual Malpractice Insurance Authority (herein after referred to as the company) is or was the carrier of my medical professional liability insurance, and as such the 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 my attorney-client privilege.

I am requesting that certain information from the company be provided concerning my claims history. I authorize the company to release information relating to claims and suit against me which is on record with the 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 representative and I agree to maintain this information as confidential. This 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 the company in writing so that the company may determine the appropriateness of contesting such disclosures.

I understand that neither the companynor 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 branch or the confidentiality of this information other than as stated herein either by me or my representatives, and, in addition to all other remedies, the company shall be entitled to specific performance and injunctive or other equitable relief.

____ _______________
Signature of Insured or Policyholder Representative Date

____
Printed Name of Insured or Policyholder Representative