Authorization to Release Information

I hereby authorize the University of Mississippi Medical Center (UMMC) to disclose to the person or entity listed below any and all information and documents that may be relevant to an evaluation of my professional qualifications, my clinical competence, my malpractice insurance claims history, and/or my moral and ethical qualifications. I expressly waive any privilege or right of confidentiality concerning this information and I hereby release from liability UMMC, and its members, officers, employees and agents for providing the above information in good faith. I understand that the Office of General Counsel will generate a letter describing my professional liability claims history at UMMC and/or verifying my professional liability insurance at UMMC, based upon my election below. I attest that the information that I have provided in my application packet is accurate and complete to the best of my knowledge. I understand that a photocopy or facsimile of this waiver shall be as effective as the original when so presented.

SECTION 1: INFORMATION NEEDED		
Please check all that you are requesting.	☐ Claim History	☐ Professional Liability Coverage

SECTION 2: APPLICANT INFORMATION		
Last Name:	First Name:	Middle Name/Initial:
Maiden Name: (if applicable)	Last Four Digits of Social Security Number:	Gender:
Mailing Address:		
City:	State:	Zip:
Phone Number:	Cell Phone:	Email Address:

SECTION 3: STATUS WHILE AT UMMC	
Department:	Dates of Employment: (MM/DD/YY to MM/DD/YY)
Status while at UMMC: (e.g., CRNA, MD, PhD, DMD, resident)	UMMC Employee ID Number:

SECTION 4: ADDITIONAL INFORMATION

SECTION 5: ENTITY AUTHORIZED TO RECEIVE INFORMATION		
Organization Name:	Contact Person:	
Phone Number:	Fax Number:	Email:

_____ _____

Signature Date