CONFIDENTIALITY AGREEMENT AND RELEASE FOR CLAIM HISTORY

The purpose of the Confidentiality Agreement and Release of Claim History Form is to comply with a directive from the Missouri Medical Malpractice Joint Underwriting Association (MMMJUA) that a request for release of information be HIPAA compliant regarding the confidentiality of protected health information such as may be found in a claims history. In addition the MMMJUA and its representatives should be indemnified in writing regarding the accuracy and completeness of the information they release. Most third party releases signed by physicians or risk managers do not specifically indemnify the MMMJUA and its representatives in this regard.

The Form is self explanatory. Once the Form is signed by the insured, it should be transmitted by the third party requestor via Fax number 1 573-893-3748 for response by the MMMJUA.

CONFIDENTIALITY AGREEMENT AND RELEASE FOR CLAIM HISTORY

Insured or Policyholder_____

Federal Employer ID # __________

Insured's Current Address_____

_____

Person and Address for mailing of requested information, if different than above: _____

_____

_____

I hereby authorize the release of claims information as designated above. I authorize the Missouri Medical Malpractice Joint Underwriting Association (MMMJUA) to release information relating to claims and suits against me on record with MMMJUA as of the date below. I understand that this information is highly confidential and should not be disclosed in any manner that would cause such information to benefit any claimant. If requested or required to disclose this information in a legal proceeding, I and my representatives will immediately notify the Missouri Medical Malpractice Joint Underwriting Association (MMMJUA).

I understand that neither the Missouri Medical Malpractice Joint Underwriting Association (MMMJUA) nor its representatives makes any representation or warranty as to the accuracy or completeness of the information, and I hereby release from liability MMMJUA and all its representatives for their acts performed in good faith.

_____ _____

Signature of Insured/Policyholder Date