

Clinician Information

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| <p>Name:</p> <p>Title:</p> <p>Primary Employer:</p> |
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SIGNATURES (Release of Information and Attestation)

Note: Clinician's signature is required following this Release of Information statement.

I, Clinician, hereby authorize CRICO (A Reciprocal Risk Retention Group) Burlington, Vermont, and The Risk Management Foundation of the Harvard Medical Institutions Incorporated ("RMF," and together with CRICO (A Reciprocal Risk Retention Group) Burlington, Vermont) to release full information to _____ with respect to me or my medical professional liability coverage and/or claims history, including, but not limited to, any claim or suit or incident pertaining to professional acts or omissions asserted against me and/or my partnership or professional corporation. This information may include the name of the claimant(s), nature and date of claim(s), amounts paid, if any, and other disposition or information in CRICO's possession, custody or control on my current policy, number, and/or any other policy I have had, as well as the dates of policy coverage. If proof of insurance is being requested with this release, I understand it will not disclose claim related activity. I expressly release and discharge from liability CRICO, and all persons associated with CRICO who provide information pursuant to this release. I further authorize that a photocopy of this release be accepted with the same authority as the original.

The information I have provided is complete and accurate.

This authorization expires 30 days from the date signed unless another date is specified here: _____

Personal Signature of Clinician

Date Signed