AUTHORIZATION FOR RELEASE
PROOF OF COVERAGE / CLAIM HISTORY

I authorize the release of my liability insurance information and medical malpractice history to the following:

Name of recipient: ______________________________

Organization: ______________________________

Address: ______________________________

Phone: ______________________________

Fax: ______________________________

Email: ______________________________

Signature: ______________________________

Printed Name: ______________________________

Date: ______________________________

Email or Fax completed form to:

CoverageProof@FDInsuranceCompany.com

Fax: (904) 296-1013