AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the University of Central Florida College of Medicine Self-Insurance Program, hereafter referred to as "Program", to release to the following:

Contact Name:	
Title:	
Facility/Company:	
Mailing Address:	
City, State, Zip:	
Phone Number:	
Fax Number:	
E-Mail Address:	

any and all information, privileged or not, in the Program's dominion, custody or control, regarding claims made or suits brought against the Board of Governors of the State of Florida which arose from clinical care provided by me. I expressly waive any claim of privilege or privacy with respect to the designated release of such information, and I release and discharge the Program from liability of any kind or character in any way arising out of disclosures made by the Program in good faith pursuant to this release.

_____ _____

Name of Applicant (print or type) UCF ID Number

_____ _____ _____

Signature Date Anticipated Termination Date, If Applicable

Return completed form via fax to 352-273-5424 or e-mail: ucfisosip@mail.ufl.edu.

For questions please call 352-273-7006 and ask for Insurance Services.