AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the Florida Atlantic University 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 Florida Atlantic University Board of Trustees, and/or me as an individual, 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) FAU ID Number

_____ _____ _____

Signature Date Termination Date (including anticipated), If Applicable

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

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