

**AUTHORIZATION FOR RELEASE OF INFORMATION**

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

Contact Name:	<input type="text"/>
Title:	<input type="text"/>
Facility/Company:	<input type="text"/>
Mailing Address:	<input type="text"/>
City, State, Zip:	<input type="text"/>
Phone Number:	<input type="text"/>
Fax Number:	<input type="text"/>
E-Mail Address:	<input type="text"/>

any and all information, privileged or not, in the Program's dominion, custody or control, regarding the professional and patient general liability protections provided by the Program to the Healthcare Provider/ Student listed below and/or claims made or suits brought against the Florida State 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)

\_\_\_\_\_  
FSU ID Number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Termination Date (including anticipated), If Applicable

**Return completed form via fax to 352-273-5424 or e-mail: [fsuisosip@mail.ufl.edu](mailto:fsuisosip@mail.ufl.edu).**

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