AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the University of Florida JHMHC Self-Insurance Program, hereafter collectively 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 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 University of Florida Board of Trustees, University of Florida Jacksonville Healthcare, Inc., Shands Teaching Hospital and Clinics, Inc., Shands Jacksonville Medical Center, Inc., Shands Jacksonville Healthcare, Inc, including but not limited to antecedent corporations, not-for-profit corporations, direct service organizations, and limited liability companies in support of said UF Health entities, 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) UFID Number

_____ _____ _____

Signature Date Termination Date (including anticipated), If Applicable

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

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