AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the **Florida Affiliated Academic Healthcare Providers - A Reciprocal Risk Retention Group** (referred to as "AAHP-RRG") 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 AAHP-RRG's dominion, custody or control, regarding the professional liability protections provided by the AAHP-RRG and/or claims made (including Notices of Intent and suits) which arose from clinical care provided by me, the AAHP-RRG Insured listed below. I expressly waive any claim of privilege or privacy with respect to the designated release of such information, and I release and discharge the AAHP-RRG from liability of any kind or character in any way arising out of disclosures made by the AAHP-RRG in good faith pursuant to this release.

Name of AAHP-RRG Insured

AAHP-RRG Policy

Signature

Date

Policy End Date (including anticipated), If Applicable

* **Return completed form via the online process: https://flbog.sip.ufl.edu/fl-aahp-rrg-release-of-information/**

* **For questions, please call AAHP-RRG Insurance Services at 352-273-7006 or 844-693-5747, or email at**