POSITIVE PHYSICIANS INSURANCE COMPANY™

AUTHORIZATION RELEASE FORM

Insured Information:

Insured Full Name: _____

Insured Previous Last Name (if applicable): _____

Date of Birth: _____ NPI #: _____

Insured's Policy #: _____

Release To:

Name: _____

Company: _____

Phone Number: _____ Ext: _____

Email to: _____

This document serves as written authorization to release credentialing, coverage, and claims history information regarding any coverage while insured with Positive Physicians Insurance Company. By signing below, I authorize the release of this information to the indicated requestor above, organization, its designated agents, employees, or representatives. I agree to indemnify and hold Positive Physicians Insurance Company harmless for any liability, expense, or claims arising from the release of this information.

Signature of Insured: _____ Date: _____

Name (printed): _____

This consent form is not valid without your complete written signature. This completed and signed form may be uploaded to our website or emailed to credentialing@positivephysicians.com.