

**Sanford Authorization for Release of Provider Claims History**

**Instructions to Provider:** Review this entire form. If you agree to terms within this document, complete all blanks, and then date and sign the bottom of the form.

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I authorize Sanford, its subsidiaries, employees, agents, and representatives (collectively “Sanford”) to provide and its representatives   
 Name of Group or Organization

with any and all information and documentation requested related to my professional liability claims and lawsuits that have been reported and covered by Sanford. I understand this information may be sensitive and may otherwise be confidential and privileged.

I release Sanford from all liability related to the disclosure of this information if the information is disclosed in good faith and without malice. I agree not to sue or bring any other claim against Sanford for providing this information and/or any other action that may result from the provision of that information.

I understand Sanford has taken reasonable steps to ensure that the information contained on a claims history report is accurate. I further understand that mistakes may occur from time-to-time in the provision of this information. I release Sanford from any liability due to incorrect, misdelivered, or otherwise inapplicable information if such errors occurred in good faith, and if upon Sanford’s discovery of the error, Sanford takes reasonable action to correct the information provided.

This authorization expires one year from the date of my signature unless another date is specified here: .

I acknowledge I have read and understand this document.

Date:   
 Signature of Provider

Printed Name of Provider