

**South Carolina Medical Malpractice Association**  
**550 South Main Street, Suite 525, Greenville, SC 29601 – corporate office**  
**864.240.5449 main    866.893.6270 toll-free    864-240-2750 fax**  
**www.scmma.net**

**SC MMA**  
**AUTHORIZATION TO RELEASE POLICY INFORMATION FORM**

Instructions:

1. Please complete, sign and date this authorization, and return via email to Teresa Anderson at the SCMMA:  
**Please Email Completed Form to: [Teresa.Anderson@marsh.com](mailto:Teresa.Anderson@marsh.com)**

**A. INSURED INFORMATION:**

1. Insured name: \_\_\_\_\_
2. SCMMA/JUA policy #: \_\_\_\_\_    2a. Effective dates: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ - \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
SCPCF policy #: \_\_\_\_\_    2a. Effective dates: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ - \_\_\_\_ / \_\_\_\_ / \_\_\_\_
3. Practice/Entity name: \_\_\_\_\_
4. Please accept this as my request and authorization to release the following:
  - 4a.  Claims History & Coverage Verification / Loss Runs (Please allow 2 weeks for this request to be processed.)
  - 4b.  Copy of my Declarations Page
5. Please forward this information to:
  - 5a. Company name: \_\_\_\_\_
  - 5b. Attention: \_\_\_\_\_
  - 5c. E-mail address: \_\_\_\_\_
  - 5d. Fax #: \_\_\_\_\_

**B. AUTHORIZATION:**

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

*The information contained in this transmission is privileged and confidential. It is intended only for the use of the SCMMA. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copy of this transmission is strictly prohibited. If you have received this transmission in error, please notify us immediately by telephone and return the original message to the South Carolina MMA via the U.S. Postal Service. Thank you.*