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

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