AUTHORIZATION FOR RELEASE OF INFORMATION

This is a request for: ☐ **Certificate of Liability Protection** ☐ **Claims History**
(check all that apply)

I hereby authorize the University of South Florida Self-Insurance Program to release to the following:

Contact Name:	
Facility/Company:	
City, State, Zip:	
Phone	
E-Mail Address:	

USF Employee
Contact Number:

any and all information, privileged or not, in the Program's dominion, custody or control, regarding claims made or suits brought against the Board of Governors of the State of Florida which arose from clinical care provided by me. I expressly waive any claim of privilege or privacy with respect to the designated release of such information, and I release and discharge the Program from liability of any kind or character in any way arising out of disclosures made by the Program in good faith pursuant to this release.

Name of USF Employee	Department/Specialty	Please Select Status
Signature	Date	Last Day with USF (If applicable)

Return completed form via e-mail: usfsip@usf.edu
For questions, please call: 813-974-8008