

CONSENT TO RELEASE INFORMATION

The undersigned hereby consents to release information concerning their professional liability insurance coverage and claim history to the entity named below.

It is understood that we will forward the requested information to the address below. The claim history will include:

- Date of medical incident.
- Description of the incident.
- Closed claim indicator with indemnity amount paid.
- Open claim indicator with potential indemnity payment.

Name and Address of Health Care Practitioner:

Name: _____

Address: _____

Signature of Health Care Practitioner: _____

Date: _____

Entity to which this information is to be sent:

**The Keane Insurance Group, Inc.
10777 Sunset Office Drive, Suite 200
St. Louis, MO 63127
Office: (314) 966-7733
Fax: (314) 966-7797**