Consent to Release Information

To: Doctors Professional Liability Risk Retention Group, LLC

Email: customercare@prms-us.com **Fax:** 888-600-6280 **Web:** DPLRRG.COM

Consent to Release Information: Policy # _____

I, _____, authorize **Doctors Professional Liability** to release my:

Primary Insured Name

- ☐ Certificate of insurance
- ☐ Claims History Report
- ☐ Credentialing

To be sent to: _____

Print Name of Intended recipient or self

Via Email: _____

Fax#: _____

I hereby authorize **Doctors Professional Liability Risk Retention Group, LLC**, its officers, employees and any agents from any claims, liabilities, actions, damages, or otherwise, arising out of the release of the requested. Loss runs contain claims information for all years of coverage under Doctors Professional Liability Risk Retention Group, LLC.

_____ _____

Insured's Signature Date