SVMIC®
State Volunteer Mutual Insurance Company

101 Westpark Drive, Suite 300
Brentwood, TN 37027-5031
Phone 615.377.1999
www.svmic.com

AUTHORIZATION AND RELEASE FORM

From: _____ Medical License Number: _____ State _____

RELEASE OF INFORMATION TO:
(Complete Address)

TENNESSEE PHYSICIANS' QUALITY VERIFICATION ORGANIZATION, LLC
1092 CHAMBERLAIN AVE, SUITE B
CHATTANOOGA, TN 37404

State Volunteer Mutual Insurance Company ("SVMIC") is the carrier of my medical professional liability insurance, and as such SVMIC maintains certain information regarding my medical practice -- specifically the history of any malpractice claims against me. I understand that this information is extremely sensitive and confidential. I acknowledge that SVMIC is protective of this information and will only release it upon my express and unambiguous consent and direction. I have decided, for reasons related to my practice, that certain information from SVMIC be provided as requested. I authorize SVMIC to provide to the above person or organization information relating to many professional liability claims activity against me that has been reported and covered by SVMIC, but specifically limited to: a) Claims that have resulted in paid losses (settlements), and/or b) Lawsuits (open or closed).

I HEREBY RELEASE SVMIC, ITS OFFICERS DIRECTORS, EMPLOYEES AND AGENTS FROM ANY CLAIMS, LIABILITIES, ACTIONS DAMAGES OR OTHERWISE, FOR THE RELEASE OF SUCH INFORMATION IF SUCH RELEASED INFORMATION IS DELIVERED IN GOOD FAITH AND WITHOUT MALICE. I ALSO ACKNOWLEDGE THAT MISTAKES MAY OCCUR IN THE PROVISION OF SUCH INFORMATION, AND WITHOUT LIMITING THE FOREGOING, I SPECIFICALLY RELEASE SVMIC, ITS OFFICERS DIRECTORS EMPLOYEES AND AGENTS FROM ANY CLAIMS DUE TO INCORRECT, MISDELIVERED, OR OTHERWISE INAPPLICABLE INFORMATION IF SUCH ERRORS OCCURRED IN GOOD FAITH, AND UPON DISCOVERY, SVMIC TAKES REASONABLE CORRECTIVE ACTIONS.

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL SPECIFICALLY REVOKED BY ME IN WRITING.

By typing your name below, you acknowledge that it serves as a legal equivalent to your handwritten signature, signifying your agreement to the terms and conditions outlined above.

_____
Print Name

_____ _____
Signature of Insured Date

Policy Number _____

For Extender Employees - Please Provide Name of Employer _____

Last revised on 10/15/2024

Submit Reset