

## **CONFIDENTIALITY AGREEMENT AND RELEASE FOR CLAIM HISTORY**

The purpose of the Confidentiality Agreement and Release of Claim History Form is to comply with a directive from the Mississippi Tort Claims Board that a request for release of information be HIPAA compliant regarding the confidentiality of protected health information such as may be found in a claims history. In addition the MMAP and its representatives should be indemnified in writing regarding the accuracy and completeness of the information they release. Most third party releases signed by physicians or risk managers do not specifically indemnify the MMAP and its representatives in this regard.

The Form is self explanatory. Once the Form is signed by the insured, it should be transmitted by the third party requestor via Fax number 888.371.4841 for response by the MMAP.

**CONFIDENTIALITY AGREEMENT AND  
RELEASE FOR CLAIM HISTORY**

**Insured or Policyholder** \_\_\_\_\_

**Federal Employer ID #** \_\_\_\_\_

**Insured's Current Address** \_\_\_\_\_

\_\_\_\_\_

**Person and Address for mailing of requested information, if different than above:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I hereby authorize the release of claims information as designated above. I authorize the Mississippi Medical Malpractice Availability Plan (MMAP) to release information relating to claims and suits against me on record with MMAP as of the date below. I understand that this information is highly confidential and should not be disclosed in any manner that would cause such information to benefit any claimant. If requested or required to disclose this information in a legal proceeding, I and my representatives will immediately notify the Mississippi Medical Malpractice Availability Plan (MMAP).

I understand that neither the Mississippi Medical Malpractice Availability Plan (MMAP) nor its representatives makes any representation or warranty as to the accuracy or completeness of the information, and I hereby release from liability MMAP and all its representatives for their acts performed in good faith.

\_\_\_\_\_  
Signature of Insured/Policyholder

\_\_\_\_\_  
Date