LOUISIANA PATIENT'S COMPENSATION FUND

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I am hereby authorizing and consenting to the disclosure of information by the Louisiana Patient's Compensation Fund relative to medical malpractice records and enrollment records as a participant in the Fund, which pertains to my professional qualifications, professional liability insurance coverage and malpractice claims history to the entity named below. (Please check off the information to be released):

_____ Claims History for credentialing purposes. Due to legislation that became effective 8/15/04, this office will no longer be able to provide a list of all claims filed against health care providers. Act 306 of the 2004 regular session prohibits reporting of panel requests to certain entities. Only suits can be reported. Since this agency is not a named defendant in suits, we do not receive notice and therefore we are not able to provide this information. We will only be able to provide information on claims in which a payment has been made on behalf of the provider by this agency. See 2004 Act 306 for further details.

_____ Full Claims History – **please note that by selecting this option you are waiving protection of 2004 Act 306 and all panels will be included on the list.**

Named Entity: _____

Contact Person: _____

Address: _____

_____

Phone/Fax: _____

Email: _____

Name, Address & Phone Number of Health Care Provider:

_____

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_____ _____

Signature of Health Care Provider **Date**