MONTROSE
MEMORIAL HOSPITAL

MALPRACTICE RELEASE FOR NON-COPIC INSURED

In applying for appointment/reappointment to the Medical Staff or as an Advanced Professional Practitioner of Montrose Memorial Hospital, I hereby authorize my malpractice insurance carrier _____ to release any and all information regarding malpractice insurance coverage, cancellation, claims, settlements or judgments or any other information pertinent to the performance of my position as a provider and the performance of the additional insured _____ (if any).

I understand this information will be treated with confidentiality.

_____ _____

Date Signature

_____

Printed Name

Please fax evidence of insurance and claims history to:

(970) 252-2619
Medical Staff Office
Montrose Memorial Hospital
800 South 3rd Street
Montrose, CO 81401