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Authorized Personnel Form

(Authorization for Use or Disclosure of Information regarding my Medical Liability Policy)

1. I hereby authorize the below listed individual(s) to communicate with MoDocs and to make decisions and/or changes regarding my insurance coverage to my MoDocs Medical Liability Policy.
2. I understand that I have the right to revoke or amend this authorization in writing at any time. I understand that a revocation or amendment is not effective to the extent that any person or entity has already acted pursuant to my authorization and MoDocs has acted in reliance on such authorization.
3. This authorization shall remain in force until authorized otherwise in writing.
4. This form revokes all prior Authorized Personnel Forms.

Authorized Individual(s)

_____

_____

_____

_____

_____ _____

Signature of Physician/Nurse Practitioner/Physician Assistant Date

_____

Printed name of Physician/Nurse Practitioner/Physician Assistant