Authorization to Release Medical Malpractice Claim Information

Release Information to: CaroMont Medical Group, Inc
2240 Remount Road
Gastonia, NC 28054
ATTN: CMG Credentialing
Phone: 704-671-5326 or 704-671-5496
Fax: 704-671-5308
Email: **credentialing@caromonthealth.org**

I hereby release _____, its officers, directors,
(Insurance company name)
employees, and agents from any claims, liabilities, actions, demands, 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 _____, its officers, directors,
(Insurance company name)
employees and agents from any claims due to incorrect, misdelivered, or otherwise inapplicable information if such errors occurred in good faith, and upon discovery, _____takes reasonable corrective
(Insurance company name)
actions.

_____ _____
(Signature of Practitioner/Health Care Provider) (Date)

_____
(Print Name)

Policy # _____