Authorization and Release
For Medical Malpractice Claims History

Please sign and email to Camille Lyons at Office of Legal Affairs (clyons@augusta.edu)

I hereby authorize Augusta University to disclose to the person or entity listed below any and all information and documents that may be relevant to an evaluation of my professional qualifications, my clinical competence, my malpractice insurance claims history, or my moral and ethical qualifications. I expressly waive any privilege or right of confidentially concerning this information, and I hereby release from liability the Board of Regents of the University System of Georgia, Augusta University, and its members, officers, employees, and agents for providing the above information in good faith. I understand that the Office of Legal Affairs will generate a letter describing my professional liability claims history at Augusta University, and verifying my professional liability insurance at Augusta University. **There is a $20 fee for generating this letter.** Other costs, such as express shipment fees or copies of additional documents, will also be passed on if requested by me or the recipient. I agree to be responsible for the charges.

Name: _____ Phone # _____
Please Print

Maiden Name _____

Signature _____ Date _____

Last 4 of the SS# _____ (Last 4 Digits, to assist in identification only)

Employee Identification Number: _____

Status While at Augusta University (Check One)	Dates of Employment
Faculty _____	_____
Resident _____	_____
Other (Please Specify) _____	_____

Full Name, Mailing Address, Phone and E-Mail of the Office you want to receive this information:

_____
_____
_____

The Office of Legal Affairs should bill: (Make sure we have your complete mailing address)

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