

**AUTHORIZATION FOR RELEASE  
OF MALPRACTICE INSURANCE INFORMATION**

To Whom It May Concern:

I, \_\_\_\_\_, hereby consent and request that the North Carolina Board of Nursing and its employees and/or agents be permitted to examine and obtain copies of all records relating to my file with \_\_\_\_\_ related to claims, settlements, payments and dismissals and/or any other documents maintained by this malpractice insurance carrier. I understand that by signing this document, the North Carolina Board of Nursing may review the information contained in these files in conjunction with the review process for my application for approval as a Nurse Practitioner.

I am willing that a photostat of this Authorization be accepted with the same authority as the original.

\_\_\_\_\_  
Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
(Print name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State, Zip Code)

\_\_\_\_\_  
(Area Code-Phone Number)