ELMHURST OUTPATIENT SURGERY CENTER, LLC

Verification of Professional Liability

To: _____

Name of Insurance Carrier

_____

Address of Insurance Carrier

_____

I hereby authorize the release of information to Elmhurst Outpatient Surgery Center, LLC regarding my professional liability insurance coverage to include dates of coverage, amounts of coverage and any limits in coverage. Elmhurst Outpatient Surgery Center, LLC will thereby be a certificate holder and is to be notified of the amount of my coverage and any future changes in my insurance status.

Physician's Signature	**Date**
Physician's Printed Name	**Policy Number**