Authorization for medical records/patient information

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Patient Account #: _____
_____

Patient's Allianz Global Assistance case #: _____ DOS: _____

I hereby authorize the Medical Records Department staff at _____ (Facility/Physician name) to release information from my medical records to:

Allianz Global Assistance
PO Box 71987, Richmond, VA 23255 - 1987
Telephone: 519 741 0429 **Fax: 519 742 8720**
Email: MGCC-NA-CM@allianz-assistance.ca

For the purpose of: (Please check all that apply)

__ Continued Treatment __ Legal Review __ Insurance purpose
__ Personal review of information __ Other (Please specify) _____

I limit the information to be released to the following items: (Please check all that apply)

__ All Pertinent Records
__ Discharge Summary __ Consultation __ Diagnostic test (eg. Lab, x-ray, radiology)
__ Operative Report __ Emergency Dept Report __ History and Physical
__ Dental Report __ Other (Please Specify) _____

I understand that this authorization will allow Allianz Global Assistance to use the information obtained to investigate and adjudicate my claims. I am aware that refusal to release all or any of the information listed above could result in denial of my insurance claims.

I understand that medical records may be disclosed to certain third parties for insurance adjudication purposes and assistance services by Allianz Global Assistance.

I understand that I can revoke this authorization at any time by contacting Allianz Global Assistance in writing, except to the extent that action has already been taken on this authorization.

I understand that the information disclosed pursuant to this authorization may include psychiatric, drug or alcohol, or HIV information if that applies to me; my signature authorizes the release of any such information. ___ I **do not** consent to releasing information related to: __ HIV/AIDS __ Mental Health __ Drug and/or Alcohol Abuse

Unless I revoke this authorization earlier, **it will expire 1 year from the date signed** or as specified: _____

Signature of Patient/Legal Representative _____ Date: _____

If other than patient, relationship to patient _____ Witness: _____

How can we help?

In Canada:
Allianz Global Assistance
P.O. Box 277
Waterloo, ON
N2J 4A4 Canada
Phone 519 741 0429
Fax 519 742 8720
Website www.allianz-assistance.ca

In the USA:
Allianz Global Assistance
P.O. Box 71987
Richmond, VA
23255-1987 USA

Legal Entities:
AZGA Service Canada Inc.
AZGA Insurance Agency Canada Ltd.