Release of information authorisation

Dear ............. (Patient name),

Allianz Global Assistance is the assistance company appointed by your travel insurer to act on their behalf to help customers such as yourself.

In order to help you as quickly and efficiently as possible, we need your help with some necessary formalities.

Please complete in full the Release of Information Authorisation form attached which allows us to communicate with your doctors and return it to us by fax to +61 7 3305 7005, or email to medical@allianz-assistance.com.au.

This information will help us to quickly assess the likely benefits available to you under your insurance.

Thank you for your assistance.

Kind regards,

Medical Assistance Department
Allianz Global Assistance Australia

How can we help?

AGA Assistance Australia Pty Ltd
ABN 52 097 227 177
Trading as Allianz Global Assistance
74 High Street Toowong QLD 4066
www.allianz-assistance.com.au

Medical Assistance Department
PO Box 162, Toowong QLD 4066
Tel + 61 7 3305 7262
Fax + 61 7 3305 7005
Email medical@allianz-assistance.com.au
Release of information authorisation

FAX

TO Medical Assistance Department FAX +61 7 3305 7005

COMPANY Allianz Global Assistance Australia EMAIL medical@allianz-assistance.com.au

FROM FAX

COMPANY EMAIL

DATE

CASE NO NO. OF PAGES

SUBJECT D.O.B

I hereby authorise:

- The release of any and all medical information in relation to me that is held by any hospital, organisation or individual to AGA Assistance Australia Pty Ltd trading as Allianz Global Assistance and its local agent.

- Allianz Global Assistance to use or provide any medical information held about me to such persons as considered necessary to conduct and manage my claim or medical emergency, and

- Allianz Global Assistance to release any information, including medical advice or opinions, provided to them, to any persons that Allianz Global Assistance feel may benefit from the receipt of such information, in the carrying out of their duties in relation to me and my claim.

A signed facsimile or photocopy of this document will constitute such an authority, and may be used in obtaining a copy of my HIC (Australian Health Insurance commission) records.

Signed, __ __ / __ __ / __ __ __ __
(Signature of patient, legal guardian or next of kin) (Date)

Please also provide us with the following information:

Current treating doctor’s details:
Name: ________________________________ Address: ________________________________
Telephone Number: __________________ Fax Number: __________________
Name: ________________________________ Address: ________________________________
Telephone Number: __________________ Fax Number: __________________

Local doctor’s details (in home country):
Name: ________________________________ Address: ________________________________
Telephone Number: __________________ Fax Number: __________________

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