Authorization to Release Medical Records

Insured Name

Date of Birth

Policy/ID Number

To:

Name of Health Care Provider/Facility/Organization

Address

Phone/Fax

I authorize the above named health care provider/facility/organization to release the following medical records and information to my travel health insurance provider for the purpose of claims processing:

Description of Information to be Released (e.g., dates of service, diagnosis, treatment, etc.)

I understand that this authorization is voluntary and that I may revoke it at any time by submitting a written request. This authorization will expire one year from the date signed below unless revoked in writing before that date.

Signature of Insured/Patient

Date