GENERALI
GLOBAL ASSISTANCE

Patient Authorization Form

Name of Patient:_____ Date of Birth:_____

SS# _____ Purpose of release: TRAVEL INSURANCE CLAIM

Claim # _____ Policy # _____

DOCTORS AND/OR MEDICAL FACILITIES AUTHORIZED TO RELEASE MY HEALTH INFORMATION:

Name	Address	Telephone	Fax	Dates Treated

You are authorized to provide Generali Global Assistance, its affiliates, underwriters, and any agent acting on behalf of Generali Global Assistance, with any health information concerning insurance coverage, medical care, advice, treatment, including HIV/AIDS testing, drug or alcohol abuse records, mental health records, or any other information that may have bearing on the claim for benefits submitted under the travel insurance plan.

Send to: Generali Global Assistance
Attn: Claims Department, P.O. Box 939057, San Diego CA 92193-9057
FAX: 877-300-8670
Information to be released: Physician Dictation, Physical and/or Occupational Therapy Records, Office Notes, Lab Reports, Entire Record, Other:_____

I UNDERSTAND THE FOLLOWING:

- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. Revocation of this authorization must be in writing and will not affect information already disclosed.
- Unless revoked, this authorization will expire in six months.
- I have the right to receive a copy of this authorization.
- Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy regulations.
- My treatment, payment, or enrollment may not be conditioned on signing this authorization. If I refuse to sign this authorization, benefits may not be paid under the travel insurance plan if additional health information is needed to determine my eligibility for benefits.

_____

Signature of patient or authorized person Date:

_____

If signed by an authorized person, please state your legal authority to act for the patient (e.g., parent, power of attorney, executor). Attach supporting legal documentation.