Request / Authorization for medical records

Patient Name:

Date of Birth:

Patient Address: _____
_____

Patient's assistance case #:

I, _____, hereby authorize _____{Enter Facility Name}, to furnish Allianz Global Assistance any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment that were rendered to me.

A Photostat/Faxed copy of this authorization shall be considered as effective and valid as the original.

I understand that this authorization will allow Allianz Global Assistance to use the information obtained to investigate and adjudicate my claims. I understand that I can revoke this authorization at any time by contacting Allianz Global Assistance.

I understand that the information disclosed pursuant to this authorization may include psychiatric, drug or alcohol, or HIV information if that applies to me.

This form expires six months from the date signed below.
Allianz Global Assistance requests that the medical records (including any lab results and doctor's notes) to be faxed to 1-519-742-8720. If the medical records cannot be faxed please mail them to:

Allianz Global Assistance
Attn: Allianz Global Assistance
P.O. Box 71987
Richmond, VA
23255

If you require pre-payment please fax the invoice to the above listed fax number.

_____
(Signature of Patient / Designated Legal Proxy)

_____
(Signature of Witness)

_____
(Date Signed by Above and Location)

How can we help?

In Canada:
Allianz Global Assistance
P.O. Box 277
Waterloo, ON
N2J 4A4 Canada
Phone 519 742 1691
Fax 519 741 0429
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.