Bajaj Allianz General Insurance Company

Regd. & Head Office: GE Plaza, Airport Road, Yerawada, Pune 411 006

Health Administration Team: *A - Wing 2nd Floor, Bajaj Finserv Building, Behind Weikfield IT Park, Off Nagar Road, Viman Nagar | Pune - 411 014

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM MEDICAL RECORD

PATIENT INFORMATION

Patient's Name:
Last First M.I.

Birth Date: _____/_____/_____ Case # : _____ATTN:
Month Day Year

I HEREBY AUTHORIZE (circle either Column A or Column B):

Column A	&	Column B
Bajaj Allianz General Insurance Company (BAGIC)		►
To Release Information Regarding My Health History, Allergies, Ongoing or Previous Health Conditions, and Current Health Status and/or Injuries to:		**To Release Information Regarding My Health History, Allergies, Ongoing or Previous Health Conditions, and Current Health Status and/or Injuries to:**
My employer, my insurance company/companies, service providers who may be involved in my care, and personal representatives or family member involved in my care		Health Administration Team (,HAT)

Purpose of Disclosure

The purpose of disclosure to is to arrange to treat your condition, obtain payment for that treatment, or to run BAGIC normal business operations.

BAGIC is required by applicable federal and state law to maintain the privacy of your medical information.

Expiration Date: 1 year (365 days) from date of patient signature

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that we have already taken action based on your authorization. To revoke this authorization, please write to the Privacy Official at 3600 Horizon Blvd., Suite 300, Trevose, PA 19053.
You have a right to refuse to sign this authorization. BAGIC may be limited in its ability to provide its contractual services to arrange for emergency health care services for you if you do not sign this authorization.
By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. This information may be used or disclosed again by the recipient(s) and may no longer be protected by federal and state law.
You have a right to receive a copy of this form after you have signed it.

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

Patient Signature: _____

Print Name of Patient: _____ Date:

Parent, Guardian, or Authorized Representative: _____

Relationship to Patient: _____

The patient, patient's guardian or authorized representative must be provided with a copy of this form after it has been signed.