NOW HEALTH INTERNATIONAL

Authorisation for Release of Medical Information Form

Please complete and sign the following authority for the release of **Your** medical information. **We** ask **You** also to refer to section 3.6 of **Your** members' handbook which outlines the additional information **You** may be asked to provide in the event of a claim. Please note that if **You** do not allow **Us** reasonable access to this information, **We** may not be able to process **Your** claim.

Member Details

Member name:

Membership number:

Date of birth (dd/mm/yyyy): / /

Medical facility details

Medical facility/treating **Medical Practitioner**:

Email:

Telephone number:

Fax:

Medical details

I/the member named above authorise the above medical facility/treating **Medical Practitioner** to release the following medical records and confidential information to Now Health International (Europe) Limited or to its authorised representative:

☐ Complete record

☐ Records of care from (dd/mm/yyyy) / / to (dd/mm/yyyy) / / only

☐ Records of care concerning the following **Medical Condition(s)**:

☐ Other. Please specify:

☐ Authorisation to confer with above named treating **Medical Practitioner** orally about information in my medical record

Authorisation

I understand that I may have access to the medical information requested and may equally decline its release (preventing the assessment of my claim) and hereby consent to Now Health International (Europe) Limited or to its authorised representative obtaining medical information from the above medical facility/treating **Medical Practitioner.**

A photocopy or facsimile of this authorisation shall be considered as effective and valid as the original.

Signature of member/authorised representative:
(parent/legal guardian/next of kin)

Date (dd/mm/yyyy):

/ /

Note: Now Health International (Europe) Limited **will not pay for the release of any medical reports/records.**

Return this form by email to EuropeService@now-health.com

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