PATIENT CONSENT TO DISCLOSE HEALTH INFORMATION

Patient's full name at time of treatment: _____

Date of birth: (MM/DD/YY) _____ | _____ | _____

Address: _____

Purpose of release: **ADJUDICATION OF TRAVEL INSURANCE CLAIM**

Effective Date of Insurance Coverage: (MM/DD/YY) _____ | _____ | _____

Medical Facilities: (List all doctors consulted for this condition and hospitals where confined)

Name	*Address*	*Telephone No.*	*Fax No.*	*Dates*
_____	_____	_____	_____	_____ | _____ | _____
_____	_____	_____	_____	_____ | _____ | _____
_____	_____	_____	_____	_____ | _____ | _____

You are authorized to give **Old Republic Insurance Company of Canada** and its affiliates, reinsurers, agents, consumer reporting agency, or independent claims administrator acting on behalf of **Old Republic Insurance Company of Canada**, any information concerning insurance coverage, medical care, advice, treatment or supplies, or any other information that may have bearing on the request for benefits submitted in conjunction with the travel insurance policy.

Information to be released:

All medical records of the Patient for up to 5 years before the Effective Date of Insurance Coverage as shown above through the date of this consent as shown below as applicable based on the patients age as outlined the policy. "Medical records" includes, without limitation, diagnosis list, medication list, physician dictation, office notes, physical therapy records, occupational therapy records, pathology reports, cytology reports and the results of all laboratory tests.

Send to: **Travel Claims Department**
P.O. Box 557, 100 King St. W.
Hamilton, ON L8N 3K9
Telephone: 888-831-2222 Fax: 866-551-1704

By signing below, I understand that:

1. The information in my health record may include information relating to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
2. I have the right to revoke this consent at any time by providing my written revocation to the facility where my records are kept.
3. A revocation will not apply to information that has already been released in response to this consent.
4. A revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
5. Unless otherwise revoked, this consent will expire in six months.
6. Consenting to the disclosure of this health information is voluntary. I can refuse to sign this consent.
7. Any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I authorize Old Republic Insurance Company of Canada to disclose my health or claim information to any relevant source (e.g. airline, tour operator, travel suppliers, etc.) for the purpose of obtaining recoveries or any outstanding refunds after my insurance claim has been settled. I hereby assign to Old Republic Insurance Company of Canada any benefits or recoveries obtained from these sources for losses covered under this policy. I direct these sources to forward reimbursement to Old Republic Insurance Company of Canada with regard to these losses.

Signature of patient or authorized person: _____ Date: (MM/DD/YY) _____ | _____ | _____

Relationship/Reason patient is unable to sign: _____