PATIENT AUTHORIZATION

Patient's full name at time of treatment: _____

Date of birth: _____ Social Security Number: _____

Purpose of release: TRAVEL INSURANCE CLAIM
Medical Facilities: (List all doctors consulted for this condition and hospitals where confined)

Name	Address	Telephone	Fax	Dates

You are authorized to give Aegon, OneBeacon Insurance Company, Stonebridge Casualty Insurance Company, Monumental General Casualty Company, CSA Travel Protection, its affiliates, reinsurers, any agent, consumer reporting agency, or independent claims administrator acting on behalf of Aegon, OneBeacon Insurance Company and CSA Travel Protection, with any information concerning insurance coverage, medical care, advice, treatment or supplies, including psychiatric records, or any other information that may have bearing on the request for benefits submitted in conjunction with the travel protection plan.

Send to: **CSA Travel Protection**, P.O. Box 939057, San Diego CA 92193-9057 /
FAX: 858-810-2505

Information to be released:

Diagnosis List/Patient Identification	Cytology Reports
Physician Dictation	Physical Therapy Records
Office Notes	Occupational Therapy Records
Pathology Reports	Other:
Entire Record	

1. I understand that the information in my health record may include information relating to 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 understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in six months.

3. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand 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.

Signature of patient or authorized person: _____ Date:_____

Relationship/Reason patient is unable to sign: _____