# RELEASE FORM

TO WHOM IT MAY CONCERN

**AUTHORISATION FOR RELEASE OF MEDICAL INFORMATION**

Dear Sir, Madam,

I, _____ , being:

- ○ the "Patient"
- ○ the _____ of the "Patient" _____
  (legal representative of the Patient)

hereby authorize the treating physician who has attended to/examined the Patient to furnish/release to Europ Assistance Belgium and/or its authorized representative(s) all medical information relating to the Patient.

A copy of this authorization letter shall be construed to be a valid authorization letter as the original.

Yours faithfully,

Signature