Authority to release information

Section A – Authority to release information

I,

(print name), of

(authoriser's address),

being Executor/Trustee/Next of Kin/the Attorney under a Power of Attorney (delete not applicable) of

, do hereby consent to AIA Australia seeking and receiving any and all information from any Employer, other Insurer (including Workers' Compensation & CTP), Rehabilitation Provider, Government Authority (including Centrelink) and/or seeking medical information from any medical practitioner, hospital or other medical institution, including the professionals listed below, whom the below named insured has consulted in the past or who at any time attended them.

It is my intention that a photocopy or electronically transmitted image of this authority shall have the same effect as an original authorisation signed by me.

Full Name of insured

Date of Birth / /

Insured's residential address

State Postcode

Insured's postal address (if different from above)

State Postcode

Please sign and date below:

Full name of authoriser

Signature of authoriser

X

Date / /

Medical Practitioners/Hospitals Consulted by Insured	**Address/Contact details**	**From date**	**To date**
		/ /	/ /
		/ /	/ /
		/ /	/ /

For AIA Australia use only

Policy Number K00

Plan Name