Pre-existing Conditions/Continuation of Care Procedures Prior to Departure

Participants with

Phone: (312) 935-9200 Ext. 2006 Fax: (312) 896-5569 Email: medassistusa@axaassistance.us

AUTHORIZATION FOR
DISCLOSURE OF MEDICAL INFORMATION
AXA Reference # :

A. EXPLANATION

This authorization for disclosure of medical information is being requested from you to comply with the terms of the Confidentiality of Medical Information Act.

B. AUTHORIZATION

I hereby authorize:

to disclose to AXA Assistance, its officers, employees and/or affiliates my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form and that if the recipient authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal and

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