PLEASE ARRANGE FOR THE NAMED INSURED PERSON (OR NEXT OF KIN) TO COMPLETE AND SIGN THIS FORM AND RETURN IT TO US

Direct Tel: Tel
Direct Fax: Fax
Assistance@CegaGroup.com

For the attention of:	Cega Case Ref:
Patient Name:	Date of Birth:

Consent for the Release of Medical information (GP Consent Form)

Insured Customer Details

Home Address	
Post Code	
Phone Number	

Doctor's Details

Surgery Address	
Post Code	
Phone Number	

Declaration

I hereby authorise the release of medical information from my records to CEGA GROUP SERVICES LTD and the medical staff that are currently treating me in order that they may deal with my present medical claim. I understand that CEGA GROUP SERVICES LTD is acting on behalf of EUI Limited and I authorise the release of details of all my medical records to both parties. This is on the understanding that the information will otherwise remain confidential.

I consent that CEGA Group may:	Yes	No
Process and transfer my Confidential Medical Information, including Special Category Data in order to administer and handle my claim including medical assistance; and		
That my data may be sent to a country outside the EEA whose data protection laws are not as strong as the UK. In such circumstances CEGA Group will use its reasonable endeavours to safeguard my data.		

Signature	Date

Name in full	
Relationship to Insured Customer	

PLEASE ARRANGE FOR THE NAMED INSURED PERSON (OR NEXT OF KIN) TO COMPLETE AND SIGN THIS FORM AND RETURN IT TO US

Phone Number		
Next of Kin Signature		Date

It is the responsibility of the insured customer/next of kin to pay the costs of obtaining the medical records