Medical Release Form
医疗信息授权

Contact Us 热线服务
Tel 电话：400-816-9300

Please scan and submit completed form with appropriate signatures via e-mail to chinaservice@gbg.com
请扫描并邮件发送已完整填写且签名的表格至 **chinaservice@gbg.com**

PATIENT INFORMATION
就诊人信息

Name (Last, First, MI) ： 姓名：	Policy： 保单号：
ID： 会员号：	Date of Birth (MM/DD/YY)： 出生日期（月/日/年）：
Address 地址：	
Postal Code 邮编：	Country 国籍：
Phone 电话：	Email 邮箱：

AUTHORIZATION
授权信息

I hereby authorize any physician or other healthcare professional, hospital or healthcare-related facility, pharmacy, medical service provider, employer, benefit plan administrator, and any Federal, State or Local Government Agency, with a complete copy of any and all medical information for use and disclosure as described in this authorization. Further to release any medical and other information in your possession or control to International Claims Services (ICS) and/or their attorneys, either directly or through a representative agent acting on their behalf, any and all medical information they may request, including but not limited to, medical records, reports, charts, graphs, x-ray notes, films, and laboratory reports.

本人授权任何医生、医疗专家、医院或医疗相关机构、药店、医疗服务商、工会、保险管理方、国家或当地政府机构使用和公布该授权所含述的医疗信息的完整副本。同时授权持有本人的医疗信息或其他信息的相关机构，直接或通过其代表人，提供给理赔中心和/或其律师所需的医疗信息，包括但不限于：就诊记录、报告、图表、图形、X影像报告、拍片报告、和化验报告。

I also hereby authorize the release of all medical information regarding diagnosis, care and treatment for alcohol abuse, drug abuse or mental health. In addition, I authorize the release of any and all billing records and statements in your possession or control.

本人授权持有本人医疗信息的机构公布所有医疗信息，包括诊断、护理记录、酗酒、药物滥用或精神方面的信息， 以及相关费用记录和清单。

I also authorize ICS, its representatives or their agents to release information that is obtained pursuant to this authorization to providers of healthcare, insurers, re-insurers, or claims administrators, and any government agency as it deems appropriate solely for the purpose of evaluating and administering any claim for benefits. I further understand that information may be released as follows:

- To other persons or organizations performing business or legal services in connection with any claim;
- As may be otherwise lawfully required;
- To any person or legally authorized representative as I have so indicated;

为了正确评估本人的相关理赔福利，本人同时授权ICS，或其代表人/代理人提供给医疗机构、保险公司、再保险人或保险管理方以及任何政府机构所需的医疗信息。本人了解公布的信息：

- 可能提供至任何与该理赔业务相关的个人或合法机构
- 是依法要求的;
- 可能提供至指定的个人或合法授权代表;

This "Authorization For Release of Information" is subject to revocation at any time except to the extent that action has been taken in reliance hereon and, if not earlier revoked in writing, it shall remain valid for two (2) years from date of signature. I agree that a photocopy, e-mailed copy or facsimile (FAX) copy of the authorization shall be accepted and as valid as the original.

此"医疗信息授权"将在收到书面撤销申请后，可随时撤销，但收到申请前已经采取的行动除外。若未收到书面撤销申请，该授权函将自签名之日起算，两年内维持有效。本人同意此授权书的影印件将被视为与原件同样有效。

Insured Person 被保险人

Name 姓名:

Signature 签名:

By typing my name on this form, I am signing electronically and this electronic signature is the legal equivalent of my manual, handwritten signature. 这里输入的电子签名的法律效率等同于手写签名。

Date日期:

Parent or Duly Appointed Legal Guardian父母或法定监护人

Note: Please attach proof of legal guardianship/conservatorship, etc. 注意：请附上法律监护/接管等证明。

Name 姓名:

Signature 签名:

By typing my name on this form, I am signing electronically and this electronic signature is the legal equivalent of my manual, handwritten signature. 这里输入的电子签名的法律效率等同于手写签名。

Date日期: