RELEASE OF PROTECTED INFORMATION FORM

The sole purpose of this form is to authorise third parties to receive Protected Health Information[1] and discuss payment of invoices regarding my medical treatment.

Please complete and send us this form using one of the contact options at the bottom of the page.

I authorise OVAG International to disclose and discuss medical, financial and payment information with the following person[2] regarding my outstanding debt(s).

Person to be authorised:

Name: _____ **Relationship:** _____

Address: _____
Street

_____
City **Postal code** **State/Province/Region** **Country**

Phone number: _____ **Mobile number:** _____

Email address: _____ **Fax number:** _____

I understand that this authorisation may be cancelled by me in writing at any time. If not cancelled, this authorisation will expire when my outstanding debt has been resolved.

_____ _____
Your Signature (or Signature of Personal Representative [3]) **Date**

_____
Signatory's name in capital letters

[1] Protected Health Information (PHI) is medical and/or financial information that is created, received, transmitted or stored by OVAG International which relates to your past, present, or future physical or mental health, health care, or payment for health care, it either identifies you or provides a reasonable basis for identifying you. Except as permitted by law, OVAG International may not use or disclose PHI to persons other than those you specify on this form.

[2] One form must be completed for each authorised person.

[3] If you are acting as the Personal Representative of the individual whose PHI is to be disclosed, you must provide proof of your authority to act for that individual.

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