Version: 1.0

AUTHORISATION FOR USE / DISCLOSURE OF MEDICAL INFORMATION

Patient name		Date of birth	
Policy number		Passport/NRIC No.	

For any enquiries, please contact us at:
0966 110 8822
or
claims@ulinkmyanmar.com

[The following is to be read and signed by the above-named patient]

A. AUTHORISATION

(i) I hereby authorise the following individual, institution or organisation:

Name of treating doctor	
Name of clinic / hospital	

to provide access and furnish all necessary and relevant reports and/or medical and invoice information pertaining to my personal data and medical condition (these may include information regarding past medical history, psychological notes, drug or alcohol abuse notes, AIDS and other sexually transmitted disease related information) to **Ulink Assist Co. Ltd.**, addressed at **#16-09, Office Tower 2, Times City, Hanthawaddy Road, Kamayut Township, Yangon** including its associate companies, partners and affiliates, as may be required; and

(ii) I further authorise **Ulink Assist**, including its associate companies, partners and affiliates to have access, to use, to receive and to share for valid purpose such reports and/or information from the above-named party for the purpose of evaluating and providing my medical care, assistance services or healthcare benefits administration services, as well as to coordinate, assess and determine my entitlements, benefits and/or reimbursements in connection with my health or medical insurance coverage.

This information may be disclosed and furnished for valid purposes to the relevant insurance companies, physicians or medical practitioners and other health care providers who may be involved in my treatment directly or indirectly, and other third parties acting on behalf of my insurer.

B. DURATION

I understand this authorisation will remain effective and will automatically expire before the earlier of: i) 180 days from the date of signing hereof, and ii) when valid purpose ceases to exist. I understand I can revoke this authorisation by written notification at any time prior to such expiration date; however, my revocation will not be effective until received and does not apply to the information already provided prior to my revocation becoming effective.

C. NOTICE OF RIGHTS

I understand I have a right to obtain a copy of this authorisation by written request to Ulink Assist. An original as well as a duplicate copy of this authorisation authorises the disclosure of the information I have authorised to be disclosed. I understand that the information disclosed pursuant to this authorisation may be re-disclosed by the recipient, only to the extent permitted by the applicable laws and regulations.

D. SIGNATURE

I have had full opportunity to read, understand and consider the contents of this authorisation, and I understand that, by signing this form, I am confirming my authorisation of the use and / or disclosure of my personal data and health information, as described on this document.

If I sign this form as the Patient's Legal Representative, I understand that all references in this form to "I", "me" or "my" refer to the Patient.

Signature		Date of consent	
Print name		Relationship to patient*	

* If this authorisation is being signed by a personal representative on behalf of the patient