Mayday Assistance
2 Clifton Mews, Clifton Hill
Brighton, East Sussex,
BN1 3HR, United Kingdom

Tel: +44 (0) 1273 624661
Fax: +1 646 558 4273 / +44 (0) 1273 606390
Email: operations@maydayassistance.com

Authorisation for Use or Disclosure of Health Information

Patient Name: _____

Patient Address: _____

Patient Date of Birth: _____ Case Reference: _____

I,_____, hereby voluntarily authorise Mayday Assistance Limited medical staff, insurance partners & business partners to disclose information from my health record in any format (written, electronic and verbal) to manage, coordinate and arrange benefits with the plan's insurance company, as well as any applicable supplemental insurance.

If you would like a Designated Representative/Family Member to receive information/records and/or be apprised of your condition, check here: ☐
Name/Relationship_____ Telephone Number _____

Information To Be Disclosed

I authorise the disclosure of the following information from my medical record pertaining to my (tick box):
☐ Hospital admission (date)_____ ☐ Outpatient visit (date) _____

Information to be provided by the following facility:

Name of Facility	Address	City, Postal Code
_____	_____	_____

The information to be disclosed from my record are: (check appropriate boxes)

☐ Entire record
☐ Lab reports
☐ Clinical documentation
☐ Other (specify):_____
☐ Psychotherapy notes only (by ticking this box, I am waiving any psychotherapist-patient privilege)
☐ Radiology & imaging reports
☐ Discharge summary

If you would like any of the below sensitive information disclosed: (check appropriate boxes)

☐ Alcohol/Drug Abuse Treatment/Referral
☐ Sexually Transmitted Diseases
☐ HIV/AIDS-related treatment
☐ Mental Health (other than Psychotherapy Notes)

The purpose(s) for which disclosure is authorised (check where applicable):

☐Further Medical Care ☐ Insurance ☐ Attorney ☐ Other (please specify)_____

I understand that:

- This authorisation will expire on_____or 1 year after being signed.
- I may revoke this authorisation at any time by providing written notice of revocation to Mayday Assistance Limited, except to the extent that action has been taken in reliance on this authorisation. If this authorisation has not been revoked, it will terminate one year from the date of my signature unless a different expiration date is stated.
- The information disclosed pursuant to this authorisation, except information protected by federal and/or state regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws.

Signature of patient/personal representative (i.e. legal guardian)

_____

Print Name_____ Date _____

Signature of personal representative (please state relationship to patient)

_____

Print Name_____ Date _____