PLEASE ARRANGE FOR THE PATIENT (OR NEXT OF KIN) TO SIGN THIS FORM & FAX TO **+44 (0)1243 621 222** OR SCAN AND EMAIL TO **ASSISTANCE@CEGAGROUP.COM** QUOTING THE RELEVANT CEGA CASE REFERENCE

FOR THE ATTENTION OF:	**CEGA CASE REF:**
PATIENT NAME:	**DATE OF BIRTH:**

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

I hereby authorise the release of medical information from my medical records to CEGA GROUP SERVICES LIMITED 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 LIMITED is acting on behalf of my travel/medical insurance company and I authorise the release of details of all of my medical records to both parties. This is on the understanding that the information will otherwise remain confidential.

PATIENT'S HOME ADDRESS:	
POSTCODE:	
CONTACT TEL NO.:	

UK Doctor's Name:

UK SURGERY ADDRESS:	
POSTCODE:	
CONTACT TEL NO.:	

Declaration:

PATIENT'S SIGNATURE:		**DATE:**	

If patient is unable to sign:

SIGNATURE OF NEXT OF KIN / LEGAL REP:		**RELATIONSHIP TO PATIENT:**	
NAME IN FULL:			
CONTACT TEL NO.:		**DATE:**	

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