HUMANIA ASSURANCE MD®

Authorization to Disclose Medical Information to the Attending Physician

Identification

Policy/Application No.:

Name of person to be insured:

First name of the person to be insured:

☐ I hereby authorize and request that **Humania Assurance Inc.** provide my attending physician with the medical information collected in the course of assessing the application referenced above.

☐ I hereby authorize and request that **Humania Assurance Inc.** provide my attending physician with the reasons underlying their decision, as well as the medical information collected in the course of assessing the application referenced above.

Identification of the attending physician

Full name of attending physician:

Name of medical clinic or hospital:

Address:

(n° and street)

(city) (province) (postal) code

Fax:

Signature

Insured's signature _____ Date:

year / month / day