Talent Trust

RELEASE OF MEDICAL INFORMATION FORM (ROMIF)

Aetna, the medical insurance company, kindly requests you to complete and sign the following authority for release of medical information.

AUTHORISATION

I hereby authorise any doctor of medicine, hospital or other person who has attended or examined me, to furnish the company or the authorised representative, any and all information with respect to sickness or injury, medical history, consultation, prescriptions, or treatment and copies of all hospital and medical records. This information is required by Aetna in order to confirm coverage for my medical condition and proposed treatment.

A photocopy or facsimile of this authorisation shall be considered as effective and valid as the original.

NAME OF THE INSURED / PATIENT: _____

CASE NO: _____

SIGNATURE OF INSURED / DESIGNATED AUTHORITY: _____

NAME OF SIGNATORY: _____
(PLEASE PRINT)

RELATIONSHIP TO PATIENT (IF DESIGNATED AUTHORITY): _____

ADDRESS: _____

DATE: _____

NAME & ADDRESS OF GP: _____

_____