

## Access to Medical Reports Act 1988

This policy is insured by Union Reiseversicherung UK (URV), if they or any of their agents require information from your doctor in respect of your insurance you have certain rights under the Access to Medical Reports Act 1988 :-

- Your consent\* is required before URV or anyone acting as their agent can apply for a report and you may see the report before it is supplied to URV or their agents, or at any time during the six months after that.
- If you disagree with the contents of the report or consider it to be misleading you may ask your doctor to amend it. If the doctor disagrees you may add your own written comments. The doctor may withhold all or part of the report from you if he/she thinks that this would be in your best interests, or that of others. . Alternatively you can refuse consent\*.
- At no time will the report be sent to URV or anyone acting as their agent without your consent\*.

PO Box 420  
Hadlow  
Kent  
TN9 9DE

tel: 08453 707 187  
fax: 0870 620 5001  
web: www.tif-plc.co.uk

\* You can refuse to give your consent however this may mean we are unable to deal with your claim

In order for us to obtain the required report would you please be kind enough to complete and sign the details below and return this form to us at the address given above which will allow us to contact your / the patient's General Practitioner for more detailed information which will assist in the assessment of your claim.

Charges made by the doctor for providing such a report to URV are for your own account, as they are not covered by this policy.

### Details of your/the patients usual General Practitioner:-

Name of patient	
Name of General Practitioner	
Surgery address	
Postcode	
Telephone number	
Hospital admitted to (if applicable)	
Name of consultant	

### Declaration

I consent to URV or anyone acting as its agent seeking medical information from any doctor who has any at any time attended me concerning anything which affects my / the patient's physical and / or medical health. I authorise the giving of such information during and after my lifetime.

I have been informed of and understand my rights under **Access to Medical Reports Act 1988** (see above).

I do / do not wish to see any report before it is sent.

I do

I do not

Patients Address			
Postcode			
Date of Birth	DD	/	MM / YYYY
Signature of patient/next of kin			
Print Name		Date	DD / MM / YYYY