Release from medical confidentiality obligation

Please complete this form with your particulars and travel information and sign the following release from confidentiality obligation.
The document must then be forwarded to your attending physician.

Policy no.

Claim no.
(filled in by Allianz Travel)

Personal details

Last name, first name

Date of birth

Street / no.

ZIP / town

Telephone private

Telephone work

Date of arrival

Date of departure

Release from confidentiality obligation

I am aware that, in order to assess its indemnifaction obligation, Allianz Travel (Switzerland) will check information which I have provided to substantiate my claim. For this purpose, I release all involved doctors and their assistants, who are named in the documents I submit or who are involved in the treatment, from their confidentiality obligation, even after my death. However, this release applies in respect of a previous treatment so far as this information is necessary to check the indemnifaction obligation. Furthermore, I release the doctors of confidence of Allianz Travel (Switzerland) from their medical confidentiality obligations towards employees of Allianz Travel (Switzerland) who are involved in processing the reported claim. I am aware that Allianz Travel (Switzerland) may, if necessary during the claims settlement process, wholly or partially rely on the services of legally independent Allianz Group companies in Switzerland or elsewhere in Europe that are subject to comparable standards of data protection. I hereby consent to personal data relating to me or my claim, including sensitive personal data, being made available to the aforementioned service companies for processing in connection with said purpose.

Place, date

Signature of the insured person (in the case of minors their legal representative)

AWP P&C S.A., Saint-Ouen (Paris), Wallisellen Branch (Switzerland)
Richtiplatz 1, 8304 Wallisellen, tel. +41 44 283 32 22, fax +41 44 283 33 83
claims.ch@allianz.com, www.allianz-travel.ch

Allianz Travel

Medical report

Health care costs for visitors

Policy no.

Claim no.
(filled in by Allianz Travel)

1. a) Case history with date of the first consultation

b) Diagnosis with start of illness resp. accident date

2. a) Were any medicine prescribed? ☐ Yes ☐ No

If yes, which ones?

b) Were there further treatments of follow-ups arranged? ☐ Yes ☐ No

If yes, please provide the dates

c) Was it an inpatient treatment
(if available, please enclose a discharge report)? ☐ Yes ☐ No

If yes, where? from / to

3. a) Are other parties involved in the treatment
(doctors, hospitals, therapists etc.)? ☐ Yes ☐ No

If yes, which ones?

b) Is the treatment finished? ☐ Yes ☐ No

If yes, date of the final treatment

If no, date of the intended final treatment

Place, date

Doctor's signature and stamp

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