

## Consent to Release of Information

### A. Authorization

I hereby authorize Group Medical Services to provide to and discuss with Johnson Fu Insurance Agency Inc. (the "Claims Assistant") all information and documentation, including medical and other personal information, provided by me or obtained by Group Medical Services from third parties (collectively "records") regarding any matter for which I may make a claim to Group Medical Services under a policy of insurance. I understand that the purpose for the provision of records to and the discussion of records with the Claims Assistant is to enable Group Medical Services and insurers to determine whether and to what extent my claim may be covered by insurance and to facilitate communications about my claim. The authorization takes effect on the date set out below and may be revoked by me at any time in writing. If this authorization is revoked before the provision of records to and the discussion of records with the Claims Assistant, the assessment and processing of my claim may be delayed.

A copy of this authorization received by Group Medical Services shall be as effective and valid as the original.

### B. Signature

\_\_\_\_\_  
**Insured's Name** (print the name of the Insured)

**X**

\_\_\_\_\_  
**Signature** (Insured or authorized representative)

DD / MM / YYYY

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Authorized Representative** (print the name of the Authorized Representative)

\_\_\_\_\_  
**Relationship** (indicate the relationship to the insured)