HSR
Health Special Risk, Inc.

Travel Net

AUTHORIZATION TO RELEASE INFORMATION / PHYSICIAN'S STATEMENT

Please type or print except where signature is required

Authorization for Release of Information (to be completed by patient or patient representative)

You are hereby authorized to furnish ***Health Special Risk, Inc.*** all information you may possess, including findings and treatment rendered, x-rays and copies of all hospital or medical records, all occasioned by professional services and hospital care rendered in my behalf. The foregoing authorization is granted with the understanding that any legal rights I may ordinarily have to claim communication between us as privileged are hereby expressly and voluntarily waived. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Patient's Signature (required)______________________________ Date ______________
Including executor, executrix and legal representatives

Patient's Name______________________________ Insured's Name ______________________________

Patient's Date of Birth (mo/day/yr) ______________________________ Social Security No.________-________-________

Physician who advised trip cancellation/interruption:

Name ______________________________Telephone (   )______________ Fax (   )______________

Address______________________________ City, State, Zip ______________________________

Primary Physician ______________________Telephone (   )______________ Fax (   )______________

Address______________________________ City, State, Zip ______________________________

Physician's Statement (to be completed by physician who advised cancellation/interruption)

* If incident causing interruption occurred overseas, a letter from the physician who advised you to return home will suffice.

Primary diagnosis of injury or illness causing cancellation/interruption ______________________________

ICD9 Code ☐ ☐ ☐ ☐ . ☐ ☐

When did symptoms of illness first appear or accident occur? (mo/day/yr) ______________________________

When did patient first consult you about this condition? (mo/day/yr) ______________________________

By: (check one) ☐ telephone **or** ☐ office visit

To your knowledge, has patient ever been treated by you or another physician for this or a related condition before? ☐ yes ☐ no

If yes, please provide date(s) (mo/day/yr) ______________ Who referred patient to you? Name ______________________________

Telephone (   )______________ Fax (   )______________

Did you advise patient to cancel travel plans? ☐ yes ☐ no ☐ patient was not the traveler

If yes, please provide date you advised cancellation (mo/day/yr) ______________

How long will patient be disabled from travel? From (mo/day/yr) ______________ To (mo/day/yr) ______________

Please list all referring and treating physicians (if different from previously listed), attach additional sheet if necessary:

Name ______________________________ Specialty ______________________________

Address______________________________ City, State, Zip ______________________________

According to my records, the above information is true and complete. I also agree that I may be contacted for additional information regarding the above patient, including sending copies of medical records, if needed.

Physician's Federal ID. Number ______________________________

Physician's Signature ______________________________ Date ______________

Health Special Risk, Inc.
HSR Plaza II, 4100 Medical Parkway, Carrollton, Texas 75007 - (972) 512-5600 - (972) 512-5820 (fax) - *TravelNetClaims@hsri.com*