

**Authority to Release Information**

I, \_\_\_\_\_  
(please print name)

of \_\_\_\_\_  
(address)

Advise as follows:

1. I am a member of ..... Insurance

\_\_\_\_\_  
(Please print Member Code or Member Number)

2. I give authority for Hunters Hill Private Hospital to make inquiries regarding my membership status and to be provided with a copy of my Confirmation Certificate including the following information:

- Name
- Address
- AVANT member ID
- Policy number
- Policy start and end dates
- Policy limit
- Category of practice
- State of practice

This Authority of Release information is valid for a 3 year period from date of signing.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Member Signature)

**This completed form should be returned to Hunters Hill Private Hospital, Attn: Therese Alexander**

- By fax to 9879 3831
- By mail to 9 Mount Street, Hunters Hill NSW 2110