MEDICAL AUTHORIZATION

(permission to request and use medical information)

I HEREBY GIVE:

Name:	Date of birth:
Street:	
City + Postcal code:	Phone number:

REGARDING:

Short description of complaint:	Date of Event:

PERMISSION TO:

The academic hospital Maastricht UMC+	
And/or more specific: Attending physician:	Specialism:
Department:	

TO: medical information that relates directly to the aforementioned event as described in the accompanying letter dated ..... to be provided to the liability insurer of Maastricht UMC+, Everest Insurance, and possibly employees of Maastricht UMC+ authorized by this insurer and (medical) advisor, consultant to be engaged of damage consultancy Sedgwick, DEKRA Personal Injury or McLarens Personal Injury, which use the information obtained in strict confidence.

Maastricht UMC+	**File number: CL ....-....**
Address: P.O. Box 5800, 6202 AZ	
Email: aansprakelijkheid@mumc.nl	

Date: .....

SIGNATURE (by patient or (legal) representative):

.....

If (legal) representative:

Name of representative:
Relation to injured party:
Address:
Signature:

Attach a copy/scan of the patient's ID.