MediGuide
Closest to the Cure

Authorization to Supply Medical Information
Please submit a copy of Passport or Aadhar Card with Photo ID

To Whom It May Concern

I, _____, authorize MediGuide International LLC (MediGuide) to convey, in a private and secure format, my medical records to hospitals in the MediGuide network, without geographic restrictions. I also hereby authorize any physician, hospital, or healthcare provider to release my medical records to MediGuide.

In connection with this remote Medical Second Opinion, I have authorized MediGuide to collect all pertinent medical records and information relating to my health as well as the specific condition leading to my request for the Second Opinion. I acknowledge that MediGuide and the medical center that I will select, and/or their consulting physician(s), will rely exclusively on the medical records in rendering the Second Opinion and that MediGuide has no obligation or responsibility for the accuracy or completeness of the medical records provided by my local treating physician(s).

In addition, I recognize that since there will be no direct physical examination by the consulting physician(s), I will not have the benefit of observations and insights that can only be obtained through such a direct examination.

I understand and approve that, for the sole purpose of enhancing the quality of our services, a telephone conversation with me or my representative may be recorded. The absolute confidentiality of any such recording will be maintained.

For the purpose of fulfilling my specific request to secure one of MediGuide's additional services regarding New India Global Mediclaim Policy, MediGuide will be required to convey, in a private and secure format, portions of the above described information. MediGuide will convey this information solely to those parties necessary to fulfill the additional services requested by me, and I hereby authorize such conveyance.

Finally, I am requesting a Second Opinion from MediGuide in an effort to confirm a diagnosis previously obtained from my local physician. The responsibility of MediGuide and the selected medical center, and/or their consulting physician(s), with respect to my diagnosis or suggested treatment plan will be satisfied in full upon delivery of the Second Opinion. It is my responsibility to follow up with my local physician(s) regarding my treatment.

Member Signature: _____ Date: _____

Undertaking from the Insured in case of any Claim being admissible under the Policy

I, _____, hereby authorize_____ (Authorized Representative Name) to act as my personal representative and primary contact with regards to the Second Opinion process provided by MediGuide.

1. The above stated person shall be the sole person travelling along with me to the designated hospital where you intend to take treatment and who shall have the complete rights and authority to decide regarding the continuing the treatment or otherwise and this decision shall be binding on me. I shall not contest the decision so taken at a later date.

2. I also understand that the Sum Insured shown on the Policy schedule is maximum benefit to which i am entitled to in case of a claim being admissible under the Policy. In case of the same being exhausted during my treatment overseas the Company shall not have any liability for any further expenses and I undertake to bear the same.

Member Signature: _____ Date: _____