

Regarding:

Client :	<input type="text"/>	<input type="text"/>
	<small>First</small>	<small>Last</small>
DOB :	<input type="text"/>	<input type="text"/>
	<small>Month</small>	<small>Day</small>
	<input type="text"/>	<input type="text"/>
	<small>Year</small>	
Address :	<input type="text"/>	
	<small>Address line 1</small>	
	<input type="text"/>	
	<small>Address line 2</small>	
	<input type="text"/>	<input type="text"/>
	<small>City</small>	<small>State/Prov</small>
	<input type="text"/>	<input type="text"/>
	<small>Zip/Postal Code</small>	<small>Country</small>
Phone :	<input type="text"/>	<input type="text"/>
	<small>Area Code</small>	<small>Phone Number</small>

CLIENT CARE MANDATE

Dear Sir,

I hereby request that MedExtra provide Case Management services to assist me in obtaining Medical care in Canada, the United States or any other jurisdiction and to discuss my case as they deem necessary with other healthcare providers (including but not limited to: case managers, clinicians, institutions or networks).

I consent to MedExtra collecting information about my medical health from healthcare providers or institutions where I have been seen or treated. I have separately executed a "Release of Medical Information" form for MedExtra to collect this information. The purpose of the collected information is the provision of Case Management services.

I understand that part or all of my medical chart on file with MedExtra may be transmitted in order to discuss my case.

Signed at: _____ On _____

By:(Print Name) _____

Signature: _____

CLIENT REPRESENTATIVE

I authorize the following individual to be in contact with MedExtra on my behalf and represent me. By signing below, I authorize the listed individual to determine and instruct MedExtra on a course of action regarding my diagnosis or treatment. I understand that this authorization is in effect until MedExtra receives a revocation signed by me.

Representative _____

Signed at: _____ On _____

By:(Print Name) _____

Signature: _____

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Phone :	(<input type="text"/>)	<input type="text"/>
	<small>Area Code</small>	<small>Phone Number</small>

INFORMATION RELEASE

I the undersigned hereby authorize and direct you to furnish MedExtra with all the information, opinions and reports that they may request from you, as necessary, including but not limited to copies of my files, medical charts, reports and test results, and all other documentation, as well as all materials, including but not limited to slides and blocks, relating to me. As well, your full co-operation with MedExtra is respectfully requested.

Signed at: _____ On _____

By:(Print Name) _____

Signature: _____