<＝様式第３号＞

【英語版】

Agreement of Authorization

・Starting date of treatment　　Year＿＿＿＿ Month＿＿ Day＿＿

・Insured（Patient）
（Name of the insured）＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿
（Address）＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿
（Date of birth）　Year＿＿＿＿ Month＿＿ Day＿＿

To: Gifu City　Office
I (patient who has received treatment),＿＿＿＿＿＿＿＿ and my head of house hold, ＿＿＿＿＿＿ authorize the City Office or its staff, and its subcontractors to refer and obtain any and all factual information related to an overseas medical treatment benefit claim(s) filed or to be filed including date of the treatment, place, and any treatment records and information from the medical organization in order to verify by submitting the related application forms.
Also, I agree to submit a photocopy of my passport.

Signature

Insured person who has received treatment shall sign one's signature. However, in the following case, guardian (insured person is under age), guardian of adult (insured person is adult ward), heir (insured person is dead) shall sign one's signature.

（Signature）＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿
（Address）＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿
（Date）Year＿＿＿＿ Month＿＿ Day＿＿

(Relation to the insured)：Self　・Guardian　・　Legal heir　　・　Other

※This agreement of authorization expires six month after the signed date.