Avant Insurance

Authority to Release Information

I, ____ ,

Avant Insured's Full Name

Avant Member ID ____

Member Code or Member Number

hereby authorise Avant Insurance Limited (ACN 003 707 471) to provide confirmation of my indemnity insurance to the medical facility/ies(named in full) listed as follows:

____

____

The information provided may include the following details:

- name
- address
- Avant member ID
- policy number
- policy start and end dates
- policy limit
- category of practice
- State of practice

This authority will continue until otherwise revoked in writing by myself.

Signed:_______________________________ Date: _________________

Avant Insured's Signature

This completed form should be returned to Avant Insurance Limited:

- by fax to 1800 228 268
- by mail to PO Box 746, Queen Victoria Building NSW 1230