COMBINED INSURANCE

Canadian Head Office
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COMBINED ASSURANCES

Claim #

RECORD OF HOSPITAL CARE

TO BE COMPLETED BY THE HEALTH RECORDS

The patient is responsible for securing this form and for charges made for its completion.

Patient's Name _____

Care Unit	Admission Date	Admission Time	Discharge Date	Discharge Time
	MM/DD/YYYY	(HR:MIN)	MM/DD/YYYY	(HR:MIN)
Emergency				
Intensive care				
Active care				
Extended or convalescent care				
Other units				

Final Diagnosis

Hospital's Name		
Signature and stamp of department official	_____ Signature _____ Printed Name Telephone Number	Date

AUTHORIZATION TO RELEASE INFORMATION: I authorize Combined Insurance, any healthcare provider, any insurance or reinsurance company, administrators of government benefits or other benefits programs, or any person having knowledge of me or my health, other organizations or service providers working with Combined Inurance, located within or outside Canada, to exchange personal information when relevant for the purposes of investigating, assessing and administering my claim(s).

This authorization shall remain valid for the duration of my claim(s) for benefits or until otherwise revoked by me in writing.

Signature of Claimant _____ Date _____