Authority to Release Information

Avant Mutual Group Limited
ABN 58 123 154 898

Registered Office
Level 28 HSBC Centre
580 George Street Sydney NSW 2000

PO Box 746 Queen Victoria Building
Sydney NSW 1230

DX 11583 Sydney Downtown

www.avant.org.au

Telephone 02 9260 9000 Fax 02 9261 2921
Freecall 1800 128 268 Freefax 1800 228 268

I, _____

Avant Insured's Full Name

Avant Member ID: _____

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:

Hospital Name	State

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