Agreement of Authorization
（海外療養費支給申請に係る調査に関わる同意書）

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

・Patient
（Name of patient）＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿

（Address）＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿

（Date of birth）　Year＿＿＿＿Month＿＿Day＿＿

To: Sendai City
I (patient who has received treatment),＿＿＿＿＿＿＿＿＿＿＿＿＿＿ and my head of house hold, ＿＿＿＿＿＿＿＿＿＿＿＿＿＿ authorize Sendai city 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 if it is necessary along verification process written above.

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 patient)：　Self ・　Guardian ・　Heir　・　Other

※ Please fill it out about all the underline parts.

Also, we might ask you to fill out the formatted documents if countries or regions, and medical institutions required submitting their format of agreement of authorization or authorization letter.