Waiver of medical confidentiality

I, the undersigned, hereby give my permission and consent to any Person and/or Institution, including any

Doctor, Hospital, Medical Center, Sick Fund, Medical Insurance Organization, and/or other Medical

Personnel and/or Medical Institution or their branches, and/or to _____ and/or his representative and/or any person so empowered by him and/or his agent any and all information, details, files, documentation, barring none, and in the manner requested by the above in connection with my medical condition and/or medical treatments administered to me and/or hospitalization until _____.

I hereby waive any and all rights of medical Secrecy and/or Privacy and/or Confidentiality in connection with the above information, details, documents and files as mentioned above, and relieve you and your agents herewith from any obligation in relation to Medical Secrecy and/or Privacy and/or Confidence, and declare that I shall have no complaint or claim of any kind whatsoever against you with regard to the above.

I hereby agree that all the above information, details and documentation will be sent directly to the above or to his agents and/or be delivered to his representative.

I hereby supply the following information regarding myself.

First Name: _____ Surname: _____ Father Name: _____ Address:

_____

Passport Number: _____.

Date: _____

Signature: _____