調査に関わる同意書

Agreement of Authorization

| ·治療開始日(Starting da | te of medication) | (西暦) | 年 (Year) | 月(Month) | ∃ (Day) |
|-----------------------------|-----------------------|-------------------|-----------------------|-------------------------|---------------------------|
| ・患者(Patient) (両方 | · ぶお書きください。) | | | | |
| (患者名) | | (Nar | ne of nationt) | | |
| (/ / - | | | | | |
| (11/71) | | (1100 | | | |
| (生年月日) (Date of | birth) <u>(西暦)</u> | 年(Year | e) 月 (Mon | nth) 目 (Day |) |
| ナイガイ健康保険組合 御い | ш | | | | |
| 私(療養を受けた者)は、 | • | 合の職員マは | ナイガイ健康保険組 | 合が委託した事業者が | 海外痞養費由請書報 |
| にある事実(療養行為を行 | | | | | |
| 会を行い、当該者から照会に | | | | | |
| また、上記確認にあたり、 | | | | トを山崎製パン健康保障 | 検組合に提示すること |
| も併せて同意します。 | | | | | |
| | | | | | |
| To: Naigai Health Insuran | ce Society | | | | |
| I (patient who has receive | ed treatment) autho | rize Naigai H | ealth Insurance So | ciety or its staff, and | its subcontractors to |
| refer and obtain any and a | ll factual informatio | n related to ar | overseas medical t | reatment benefit claim | ı(s) filed or to be filed |
| including date of the treat | ment, place, and an | y treatment re | ecords and informat | tion from the medical o | organization in order |
| to verify by submitting the | related application | forms. | | | |
| Also, I agree to submit a p | hotocopy of my pass | port if it is ned | cessary along verific | cation process written | above. |
| | | | | | |
| | | | | | |
| | | 【署 | 名 欄】 | | |
| | | [Sign | nature] | | |
| | | | | | |
| 署名は、治療を受けた本 | | | | ぶ未成年の場合)、成年後 | &見人(本人が成年被 |
| 後見人の場合)、法定相続人 | (本人が死亡してい | る場合)が署名 | 名して下さい。 | | |
| Insured person who has re | assisted tweatment of | hall sion ana's | signatura Harrary | on in the following see | a mandian (incurse |
| person is under age), gua | | _ | _ | | |
| signature. | rulan of addit (ms | ureu person n | s adult ward), lieli | (insured person is di | sau/ shan sign ones |
| signature. | | | | | |
| (氏名)(Signature) | | | | | |
| (住所)(Address) | | | | | |
| | n to the insured) : | | | | |
| | elf)・ 親権者(Gua: | rdian)・ 法定 | 相続人(Heir)・ そ | の他(Other)〔 |) |
| (署名日) (Date) <u>(西暦)</u> | 年(Year |) | (Month) | (Day) | |
| ※ 本同意書の有効期限は | <u> </u> | です。 | | | |
| X This agreement of aut | horization expires 6 | months after | the signed date. | | |

なお、国や地域、医療機関から所定の同意書や委任状などを求められた場合、所定の書類に必要事項を記載頂くことがあります。 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.