調査に関わる同意書 Agreement of Authorization

(患者名 Name of patient)			月 Day	P
-				
(住所 Address)	<i>-</i> 3 <i>5</i> .3	П. Б.		
(生年月日 Date of birth) Year	牛 Month_	月 Day	H	
公立学校共済組合石川支部御中				
私 (療養を受けた者)、 公立学校共済組合石川支部が委託した事業者を行った日時、場所、療養内容)を確認する 行った者に照会を行い、当該者から照会に対 また、上記確認にあたり、パスポートの当 学校共済組合石川支部に提示することも併せ	者が、海外療えるため、申請書 さする情報の打 コピーが必要と	を費申請書類に 書類の提供等に。 是供を受けるこ こなる場合には、	ある事実 (療養 よって、療養行 とに同意しまっ	を行為 行為を け。
To: JAPAN MUTUAL AID ASSOCIATION TEACHERS-ISHIKAWA	OF PUBL	IC SCHOOL		
I (patient who has received treatmen	t)		authorize JA	PAN
MUTUAL AID ASSOCIATION OF PUB				
staff, and its subcontractors to refer and	obtain any ai	nd all factual i	nformation re	lated
to an overseas medical treatment benefit α	claim(s) filed	or to be filed in	cluding date o	of the
treatment, place, and any treatment				
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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.