Return this form to:

Permission to Disclose Health Information (OCF-5)

Use this form for accidents that occur on or after January 1, 1994. Collection, use and disclosure of this information is subject to all applicable privacy legislation.

Claim Number:	
Policy Number:	
Date of Accident: (YYYYMMDD)	

Part 1 Applicant Information

Last Name	First Name and Initial	Date of Accident	year month day
Address			
City	Province	Postal Code	
Birth Date: year month day	Home Telephone: Area Code	Work Telephone: Area Code	

Part 2 Insurance Company Information

Name of Insurance Company					
Name of Insurance Company Representative		Title			
Address		City			
Province	Postal Code	Telephone Number: Area Code		FAX Number: Area Code	

Part 3 Treating Health Professional

Name of Health Professional		Health Profession	
Address			
City	Province	Postal Code	
Telephone Number: Area Code		FAX Number: Area Code	

Part 4 Signature

I authorize my treating health professional to collect, use and disclose to my insurer, any information relating to my health condition and treatment received as a result of the automobile accident and any pre-existing health conditions that may be a barrier to my recovery as a result of the automobile accident, for the purpose of providing treatment and determining my eligibility for benefits. This authorization is valid one year from the date this form is signed.

Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)