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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		Work Telephone		Extension

Part 2 Insurance Company Information

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

Part 3 Treating Health Professional

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

Part 4 Signature

I authorize my treating health professional to collect, use and disclose to my insurer or to a health professional, social worker, or vocational rehabilitation expert properly appointed by my insurer to conduct an examination, only such information relating to my health condition and treatment received as a result of the automobile accident and any pre-existing or subsequently occurring health conditions that may be a barrier to my recovery as a result of the automobile accident, as is reasonably required for the purpose of providing treatment and determining my eligibility for benefits. This authorization is valid until my claim for Statutory Accident Benefits has been concluded or until I withdraw this consent. (Please note withdrawal of this consent may impact your benefit entitlement).

This authorization does not apply to a consultation between my health care provider and the insurer's health professional conducting an examination. Separate express consent is required for this consultation. This consent should be in writing.

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