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 Na	me				First Name and Initial		Date of Accident	year	month	day
Addres	3									
City					Province		Postal Code			
		month	day	Home Telephone		Work Teleph				nsion

Part 2 Insurance Company Informatior

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

Part 3 Treating	Name of Health Professional	Health F	Profession				
Health Professional	Address						
FIOLESSIONAL	City		Province	Postal Code			
	Telephone Number	FAX Numb	er				

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)