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	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 Chiropractor	
Address 101-86 Norfolk St.		
City Guelph	Province Ontario	Postal Code N1H 4J2
Telephone Number (519) 827-0040	FAX Number (519) 827-0902	

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)

SAVE