MEDAVIE BLUE CROSS™

CONSENT TO DISCLOSE PERSONAL INFORMATION

This form must be completed and signed by the person identified in Section 1, or the person's parent/guardian if he or she is under the age of 18. By completing this form, you agree that Medavie Blue Cross is permitted to provide the specified personal health, claims and/or benefit plan information to the person(s) named in Section 2.

SECTION 1 - MEMBER INFORMATION

I hereby authorize Medavie Blue Cross to release personal health, benefit plan information or related documents which pertain to the following member. (please print)

ID Number: _____ Policy Number: _____ Date of Birth (DD/MM/YYYY): _____

Last Name: _____ First Name: _____

Address: _____ City/Town: _____ Province: _____ Postal Code: _____

Daytime Telephone Number: _____ Email Address: _____

SECTION 2 - CONSENT

I hereby authorize Medavie Blue Cross to release the following personal health, benefit plan information or related documents. ***(please check all that apply)***

- ☐ Benefit plan coverage and registration information, including account payment (if responsible for paying premiums)
- ☐ Claims information (including prescription drugs, dental or health services)
- ☐ Diagnostic, treatment and/or care information
- ☐ Health Care Spending Account
- ☐ Information required for online access to the person's benefit plan, claims or account information through the secure Medavie Blue Cross Member Service website.
- ☐ Other Information (please describe): _____

The above information may only be released to the following INDIVIDUAL(S):

Note: our corporate privacy policies do not allow the direct release of personal health information to some third parties, such as the media.

Full Name	Address	Telephone Number	Relationship

or, to the following ORGANIZATION:

Name of Organization	
Contact Person	
Address	
Telephone Number	
Purpose	

Effective Date of Consent (DD/MM/YYYY): _____

Expiry Date of Consent (DD/MM/YYYY): _____
(If an expiry date is not provided, this consent will continue indefinitely)

Acknowledgement: This consent may be revoked at any time. I understand why I have been asked to provide consent to disclose my personal health, benefit plan information or related documents of either myself or of the person named in Section 1. I am aware of the risks and benefits of consenting, or refusing to consent, to the disclosure.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Name (please print): _____

Signature of the person named in Section 1: _____ Date: _____
(parent/guardian signature required if person is under the age of 18)

MEDAVIE BLUE CROSS ADDRESSES

Atlantic Provinces
PO Box 220
Moncton NB E1C 8L3
Inquiries: 1-800-667-4511

Quebec
PO Box 3300 STN B
Montreal QC H3B 4Y5
Inquiries: 1-800-667-4511

Ontario
PO Box 2000 STN A
Etobicoke ON M9C 5P1
Inquiries: 1-800-667-4511

Other Provinces and Territories
PO Box 2318 STN Main
Edmonton AB T5J OL8
Inquiries: 1-800-667-4511

- Medavie Blue Cross will not accept an incomplete consent form.
- This consent complies with federal and provincial privacy laws.
- For additional information regarding privacy policies at Medavie Blue Cross, visit medaviebc.ca or call 1-800-667-4511.

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AUTHORIZATION

I understand that the personal information I have provided herein is collected and used by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada (Blue Cross Life) to administer the terms of my policy or the group policy of which I am an eligible member, recommend suitable products and services that I am eligible for as a member of a policy, and other applicable purposes, as described in the Medavie Blue Cross Privacy Statement at medaviebc.ca.

Depending on the type of coverage I carry, limited personal information such as claim, health and/or financial related data may be collected from and/or released to following third parties as required for the purposes of administering and managing the benefits outlined in the policy of which I am an eligible member. These third parties may include healthcare providers, other insurance companies, regulatory authorities and investigative bodies, services providers, and/or the cardholder of any contract under which I am a participant.

Where allowed by law, my information may be shared with Medavie Blue Cross employees or service providers in jurisdictions other than where it was collected. If I am a resident of Quebec, this includes transferring or disclosing my personal information to Medavie Blue Cross employees or service providers outside of that province.

I understand that my consent is only valid for the time it is needed to achieve the purposes outlined herein, unless I withdraw it. I understand I may withdraw my consent at any time. However, in some instances doing so may prevent Medavie Blue Cross from providing me with certain products or services that may be useful to me and/or my dependents. This consent complies with federal and provincial privacy laws.

For more details about our information practices, including how your personal information is protected, how to access or correct personal information, or if you have concerns or questions, please see our Medavie Blue Cross Privacy Statement available at medaviebc.ca or call 1-800-667-4511. A photocopy of this authorization shall be as valid as the original.

Signature: _____ Date (DD/MM/YYYY): _____