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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.

<b>Claim Number:</b>	
<b>Policy Number:</b>	
<b>Date of Accident:</b> (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).

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