

Return this form to:

Permission to Disclose Health Information to the Designated Assessment Centre (OCF-14)

Use this form for accidents that occur on or after January 1, 1994.

Claim Number:

Policy Number:

Date of Accident:
(YYYYMMDD)

The insurance company will complete parts 1 through 3. If the applicant agrees to attend the designated assessment centre(s), the applicant must complete part 4 and return the form to the insurance company. **Permission is valid only for the assessment(s) referred to in Part 3 as completed below.**

Part 1 Applicant Information

Last Name				First Name and Initial							
Address											
City				Province				Postal Code			
Birth Date	year	month	day	Home Telephone	Area Code			Work Telephone	Area Code		

Part 2 Insurance Company

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

Part 3 Assessment Type (completed by insurance company)

The following type(s) of assessment will be arranged:

<input type="checkbox"/> attendant care assessment	<input type="checkbox"/> catastrophic impairment assessment (Bill 59 only)
<input type="checkbox"/> disability assessment	<input type="checkbox"/> residual earning capacity assessment (Bill 164 only)
<input type="checkbox"/> medical and rehabilitation assessment (including Application for Approval of an Assessment or Examination and PAF related disputes.)	

Part 4 Signature

TO THE INSURER:

I **UNDERSTAND** that you, and persons acting for you, will collect and use personal information and personal health information about me that is related to my claims for accident benefits arising out of the accident described in my application.

I **ALSO UNDERSTAND** that this information will be collected, used and disclosed for the purposes of:

- Investigating and processing my claims as required by law, including the Ontario Automobile Policy;
- Obtaining or verifying information relating to my claims in order to determine entitlement and the proper amount of payment;
- Identifying and analyzing the nature, effects and costs of goods and services that are provided to automobile accident victims by health care providers;
- Preventing and detecting fraud;
- Compiling anonymized statistics for government agencies;
- Assessing underwriting risks and claims experience; and
- Allowing you to comply with your legal obligations to others, such as government regulators, auditors and reinsurers.

I **ALSO UNDERSTAND** that you, and persons acting for you, may disclose this information to the following persons, who may collect and use this information for the purposes described above:

- Insurers; reinsurers; insurance adjusters, agents and brokers; employers; health care professionals; hospitals; accountants; financial advisors; solicitors; federal, provincial or municipal governments and agencies where required or authorized by law; police forces or law enforcement agencies; and my agents or representatives;
- Organizations designated as investigative bodies under privacy laws;
- Claims processing agencies and statistical analysis organizations to whom you are directed by law to disclose claims, payment requests and other claims information; and
- Organizations that consolidate claims and underwriting information for the insurance industry.

I **CONSENT** to you collecting, using and disclosing this information in the manner described above.

I authorize my insurance company and treating health professionals to give the Designated Assessment Centre any information relating to my health condition, and treatment and rehabilitation received as a result of the automobile accident, for the purpose of determining my eligibility for benefits. I authorize the Designated Assessment Centre to consult with my treating health professionals if necessary. I also authorize the Designated Assessment Centre to give my insurance company and treating health professionals a copy of its report.

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