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 (Area Code)	Work Telephone (Area Code)	

Part 2 Insurance Company Information

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 Treating Health Professional

Name of Health Professional	Health Profession	
Address		
City	Province	Postal Code
Telephone Number (Area Code)	FAX Number (Area Code)	

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 treating health professional to collect, use and disclose to my insurer, any 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, 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.

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