ALBERTA BLUE CROSS®

CONSENT TO DISCLOSE PERSONAL INFORMATION*

***NOTE:** This form must be completed by the individual who is the person identified in Section 1, or the person's parent or guardian if he or she is under the age of 18.

1. I hereby authorize Alberta Blue Cross to release personal health and/or benefit plan information relating to the following person (please print):

LAST NAME	FIRST NAME	BIRTHDATE (YYYY MM DD)	ALBERTA BLUE CROSS ID NUMBER

ADDRESS	PHONE NUMBER (optional)

CITY	PROVINCE	POSTAL CODE

2. I hereby authorize Alberta Blue Cross to release the following personal health and/or benefit plan information:
PLEASE CHECK ALL THAT APPLY

- ☐ benefit plan coverage and registration information, including account payment (if responsible for paying premiums)
- ☐ claims information (for prescription drugs or dental or health services)
- ☐ other information (please describe):
- ☐ diagnostic, treatment and/or care information
- ☐ information required for online access to the person's benefit plan, claims or account information through the secure Alberta Blue Cross plan member web site

3. The above information is to be released for the following purpose(s) (for example litigation, income tax):

4. The information may be released only to:

Please note that our corporate privacy policies do not allow the direct release of personal health information to some third parties, such as the media or pharmaceutical companies or their agents.

THE FOLLOWING INDIVIDUAL(S)

FULL NAME	ADDRESS	PHONE NUMBER	RELATIONSHIP
FULL NAME	ADDRESS	PHONE NUMBER	RELATIONSHIP

OR THE FOLLOWING ORGANIZATION

Name of organization	Address	Contact person (s)	Phone number	Purpose

5. Effective date

This consent is effective on: YYYY MM DD and will continue indefinitely unless an expiry date is indicated to the right: YYYY MM DD

6. Acknowledgement: Consent may be revoked by me at any time. I understand why I have been asked to provide consent to disclose the personal health and/or benefit plan information of the person named in Section 1, and am aware of the risks and benefits of consenting, or refusing to consent, to the disclosure.

Signature of person whose personal health or benefit plan information is to be released, as named in Section 1, above
(Parent/guardian if person listed in Section 1 is under the age of 18)

Name (please print)

7. PLEASE MAIL TO:

Alberta Blue Cross
Attention:

10009 – 108 St. NW
Edmonton, Alberta T5J 3C5

Notes:

- Alberta Blue Cross will not accept incomplete consent forms.
- This consent is obtained in accordance with section 34 of the *Health Information Act*, sections 7, 8 and 9 of Alberta's *Personal Information Protection Act* and section 5 of the federal *Personal Information Protection and Electronic Documents Act*.
- For more information about Alberta Blue Cross privacy policies or the collection, use or disclosure of your/your dependents' personal information, visit www.ab.bluecross.ca, call our privacy matters representative at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 – 108 St NW, Edmonton, AB T5J 3C5.