Driver Re-hab. Team
Victoria Webster
5419 Battersea Rd
Battersea, Ont. K0H 1H0
victoria@driverrehabteam.com
PHONE (613) 353-6667
FAX (613) 353-8740

Permission to Disclose Health Information

Applicant Information

Last Name		**First Name and Initial**	
Address	**City**	**Province**	**Postal Code**
Date of Birth Year Month Day		**Home Telephone**	**Work Telephone**
Claim Number	**Policy Number**	**Date of Accident**	Year Month Day

Insurance Company Information

Insurance Company		**Insurance Representative**	
Address	**City**	**Province**	**Postal Code**
Telephone		**Fax**	

Treating Health Professional

Name of Health Professional		**Health Profession**	
Address	**City**	**Province**	**Postal Code**
Telephone		**Fax**	

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 print0	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)