ALBERTA BLUE CROSS®

DISABILITY INFORMATION

(Consent provided directly by an individual)

NOTE: This form must be completed by the individual who is the subject of the personal health information and/or information regarding the disability claim submitted with a disability date of _____ to be disclosed.

As I am unable to directly communicate due to: ☐ Language Barrier, ☐ Cognitive Impairment, or ☐ Hospitalization/Palliative Care

1. I hereby authorize Alberta Blue Cross to release health information relating to the following person (please print)**:**

Surname	First name	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 information and/or information regarding the disability claim submitted with a disability date of _____ (please check all that apply)**:**

☐ short term & long term disability information	☐ health, prescription drugs or dental services claims information	☐ diagnostic, treatment and/or care information	☐ other information (describe)

3. The above information is to be released for the following purpose(s) (for example help with questions about my disability, litigation, income tax)**:**

_____

4. The information is to be released by (check all that apply)**:**

☐ verbally (by phone) ☐ FAX ☐ mail ☐ other **(please indicate)** _____

5. This information can be released only to:

Name of individual or organization		If organization, provide contact person's name
Phone number (required)	Fax number (if needed)	Mailing address (if needed):
Relationship or receiving person/organization to individual who is the subject of the information (required)		

*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.

6. Effective Date

This consent is effective on: (YYYY/MM/DD) / /	And will continue for 1 year unless I indicate an expiry date (YYYY/MM/DD): / /

7. Acknowledgment

Consent may be revoked by me at any time. I understand why I have been asked to disclose this information, and am aware of the risks and benefits of consenting, or refusing to consent,to the disclosure.

8. Signature

_____ _____

Signature of person who is the subject of the information **Name of person who is subject of the information** (please print)

_____ _____

Print Name and Signature of Authorized Representative* **Print Name and Signature of witness**

*If medically unable to communicate, the Authorized Representative must provide a copy of the Authority to Act with supporting medical in addition to this form.

PLEASE MAIL TO:
Alberta Blue Cross
Attention:_____
10009 – 108 Street 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 Act and Section 5 of the federal Personal Information Protection and Electronic Documents Act.

For more information about our privacy policies or questions and concerns related to privacy, please contact our Privacy Matters toll-free line at 1-855-498-7302 (780-498-7302 in the Edmonton area) or e-mail at privacy@ab.bluecross.ca.

*Blue Cross Life Insurance Company of Canada underwrites all life and income replacement benefits.