Release of Medical Information
Authorization Form

Patient name :
Patient DOB :
Case number:

Family Doctor's Name:	Specialist's Name:
Phone number:	Phone Number:
City/Province:	City/Province:

I (patient/designate) _____ hereby authorize the following company:

Penfield Care
310-260 Hearst Way
Ottawa, Ontario K2L 3H1
Phone: 800.705.5991
Fax: 613-880-0770
Email: claims@penfieldcare.com

To acquire and obtain all medical information regarding me, related to my claim(s), which includes current medical treatment, investigations, tests and medical history.

Therefore, I hereby authorize Penfield to use this information, in order to provide medical assistance and to evaluate and determine coverage of the fees incurred, as per my insurance policy terms and conditions.

_____ _____
Signature of Patient/Designate Date (MM/DD/YY)

_____ _____
Designate's Name & Relationship to the Patient Valid Until (MM/DD/YY)