MANITOBA
PUBLIC INSURANCE

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

Claim Number: _____

I, _____, (customers name), MHSC Registration/PHIN (nine digit number) No. _____was injured in an automobile accident on _____ (date of accident), and I have made a claim to Manitoba Public Insurance (MPI) for benefits and insurance money under Parts 1 and 2 of The Manitoba Public Insurance Corporation Act.

I authorize, _____, (name of Doctor, Chiropractor, Therapist, Hospital, etc.) located at _____ (address of care provider) to provide Manitoba Public Insurance with personal health information regarding the injuries I sustained in this accident, from the date of the accident and including up to two years of medical history prior to the date of the accident as that history relates to the injuries I sustained. This information is for the purpose of determining my entitlement to benefits and insurance money under Parts 1 and 2 of The Manitoba Public Insurance Corporation Act.

I authorize Manitoba Public Insurance to forward my personal health information to other practitioners involved in my care and to any health care practitioners to whom I may be referred for an assessment relating to my claim.

I understand that information collected on my claim may be shared with other departments within Manitoba Public Insurance for the purpose of administering its driver's licensing and vehicle registration programs, and its other insurance programs.

This authorization, or a photocopy of same, shall be your full and sufficient authority to disclose this information to Manitoba Public Insurance.

This authorization shall be valid for a period of two years from the date of signature, unless earlier revoked by me in writing.

_____ _____

Witness (anyone 18 years of age or older)

Signature of Customer/Customer's Representative

_____

Date (dd/mm/yy)

Please return the completed form to:

Manitoba Public Insurance
Injury Claims Management
P.O. Box 6300, Winnipeg, MB R3C 4A4
Or Fax to Number: 204-954-5332