Electronic Transmission Authorization and Consent Form

This form must be filled out prior to claims submitted electronically by the provider on your behalf. This form must be retained in your patient file for verification purposes for two years following closure of your patient file.

Provider: **Active Chiropractic Family Health Centre**
Address: **1169 Pembroke Street, East**
City/Province: **Pembroke, Ontario**
Postal Code: **K8A 7R4**
Phone Number: **613-732-9215**

Patient: ____
Address: ____
City/Province: ____________________________________
Postal Code: _____________________________________
Phone Number: ___________________________________
Plan Number: _____________________________________
Certificate / Plan member Number: __________________

Consent to Collect and Exchange Personal Information

Message to the Plan member, Spouse and/or Dependent regarding Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.
I authorize the insurer and / or plan administrator and their service provider(s) to:

- use my personal information for the above purposes.
- exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law(s).
I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

____
Date

______________________________ ___________________________________
Print - Name Signature

______________________________ ___________________________________
Witness - Print Witness – Signature