Authorization and Release

Allianz Global Assistance

Allianz Global Assistance Claims Department
P. O. Box 277
Waterloo, Ontario N2J 4A4
Canada
Collect worldwide: 416-340-8809
Toll-free Canada/U.S.A.: 1-800-869-6747

Claim #: ____________ OHIP #: ____________

Version Code: ____________ Date of Birth: ____________
(yy/mm/dd)

I, ______________________________, irrevocably direct and authorize the Ontario Ministry of Health and Long-Term Care ("the Ministry") to make payment in respect of my claim for out-of-country health services to AZGA Service Canada Inc. o/a Allianz Global Assistance, directly and I hereby release OHIP, upon payment to AZGA Service Canada Inc. from any further claim or cause of action in connection therewith.

Consent

I authorize the Ministry to collect my personal health information, consisting of:

- information relating to my receipt of health care services outside of Canada, and
- information relevant to the reimbursement of those services under the Health Insurance Act, R.S.O. 1990, c.H.6

from AZGA Service Canada Inc., and authorize the Ministry to disclose such personal health information as may be required for the purpose of verifying my request for payment under the health Insurance Act, including the details of any duplicate payment previously made to me, to AZGA Service Canada Inc.

I understand the purpose for the Ministry's collection and disclosure of this personal health information.
I understand that I can refuse to sign this consent form.

If providing consent on behalf of a person who is not capable to consenting to the Collection, use and disclosure of personal health information:

I, ______________________________, am the substitute decision-maker for

______________________________. I authorize the Ministry to collect personal health information about the Insured person, consisting of:

- information relating to the Insured Person's receipt of health care services outside of Canada, and
- the reimbursement of those services under the Health Insurance Act, R.S.O. 1990, c.H.6.

from AZGA Service Canada Inc., and authorize the Ministry to disclose such personal health information as may be required for the purpose of verifying my request for payment under the Health Insurance Act, including the details of any duplicate payment previously made to me, to AZGA Service Canada Inc.

I understand the purpose for the Ministry's collection and disclosure of this personal health information. I understand that I can refuse to sign this consent form. Note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.

Authorization – Insured	**Authorization – Witness**
Name:	Name:
Address:	Address:
Home Tel.: ( )	Home Tel.: ( )
Work Tel.: ( )	Work Tel.: ( )
Signature:	Signature:
Date: (yy/mm/dd)	Date: (yy/mm/dd)