Authorization to Provide Medical Information

Submit online at icbc.com/claims
or return to ICBC
PO BOX 2121, STN TERMINAL
VANCOUVER BC V6B 0L6
Fax 1-877-686-4222

CLAIM NUMBER	CLAIMS REPRESENTATIVE	DATE (ddmmmyyyy)
CLAIMANT NAME		PERSONAL HEALTH NUMBER

To whom it may concern:

I _____ or

I, _____ parent/guardian of

_____ a minor, or administrator/executor of

the estate of _____, authorize every medical practitioner, health care practitioner or provider, rehabilitation professional, dentist, ambulance owner (including British Columbia Ambulance Service and the Emergency Health Services Commission) and the employees of hospitals as defined in the *Hospital Act*, to provide and discuss with any representative of the Insurance Corporation of British Columbia (ICBC) upon presentation of this authorization or photocopy thereof:

- any and all records, x-rays and other medical imaging, information and evidence in their possession and/or,
- a report or certificate, including but not limited to the diagnosis, treatment, current conditions, functional abilities and prognosis, in any format specified by ICBC including verbal, written and electronic formats,

relating to issues raised by my claim for injuries sustained on or about _____ , **including medical history and physical condition both prior and subsequent to the above date, regardless of lapsed time, for the purposes of determining my enhanced accident benefits and managing my claim.**

This is not a release of claim for damages.

_____
SIGNATURE

_____
ADDRESS

_____

_____
PHONE NUMBER