

SCHEDULE "B"

AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

I, _____ (or I, _____
parent/guardian of _____, a minor)

hereby consent to and authorize the Ministry of Health to furnish to any representative of Medipac Assistance International Inc. any and all records and information in the Ministry of Health's possession regarding claims for Medical Services incurred while I had Insurance from

MM _____ DD _____ YY _____ to MM _____ DD _____ YY _____ including medical history and physical condition both prior to and subsequent to receipt of medical services, regardless of lapsed time and bearing in any way on the services received during the above time period.

DATED this _____ day of _____, 20 _____

Personal Health Number

Signature

Address

City Province Postal Code

Telephone