Return this form to:

Permission to Disclose Health Information to the Designated Assessment Centre (OCF-14)

Use this form for accidents that occur on or after January 1, 1994.

Claim Number:	
Policy Number:	
Date of Accident: (YYYYMMDD)	

The insurance company will complete parts 1 through 3. If the applicant agrees to attend the designated assessment centre(s), the applicant must complete part 4 and return the form to the insurance company. **Permission is valid only for the assessment(s) referred to in Part 3 as completed below.**

Part 1 Applicant Information

Last Name		First Name and Initial			
Address					
City		Province		Postal Code	
Birth Date	year month day	Home Telephone	Area Code	Work Telephone	Area Code

Part 2 Insurance Company Information

Name of Insurance Company					
Name of Insurance Company Representative				Title	
Address				City	
Province	Postal Code	Telephone Number	Area Code	FAX Number	Area Code

Part 3 Assessment Type (completed by insurance company)

The following type(s) of assessment will be arranged:

- ☐ attendant care assessment
- ☐ catastrophic impairment assessment (Bill 59 only)
- ☐ disability assessment
- ☐ residual earning capacity assessment (Bill 164 only)
- ☐ medical and rehabilitation assessment (including Application for Approval of an Assessment or Examination and PAF related disputes.)

Part 4 Signature

I authorize my insurance company and treating health professionals to give the Designated Assessment Centre any information relating to my health condition, treatment and rehabilitation received as a result of the automobile accident, for the purpose of determining my eligibility for benefits.
I authorize the Designated Assessment Centre to consult with my treating health professionals if necessary.
I also authorize the Designated Assessment Centre to give my insurance company and treating health professionals a copy of its report.

Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)