BRITISH COLUMBIA | Health InsuranceBC

SCHEDULE B
AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

Personal Health Number (PHN) of Patient

Name of Adult Patient, or Parent/Guardian of Patient	Name of Minor-aged Patient (if applicable)
Address	Telephone Number

Insurance Company	
Insurance Coverage	
FROM (YYYY / MM / DD)	TO (YYYY / MM / DD)

I, the above-named adult, hereby consent to and authorize the Ministry of Health ("the Ministry") to provide to an authorized representative of the above-named insurance company("the Insurer"), for the use by the Insurer in assessing entitlement to benefits, any and all records and information in the possession of the Ministry regarding claims for medical or health care services incurred while I had insurance coverage with the Insurer during the period noted above, including records and information relating to medical history and physical condition both prior and subsequent to receipt of the medical or health care services.

_____ *Signature of Adult (Patient or Parent/Guardian of Patient)*

Date Signed (YYYY / MM / DD)

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