

MEDICARE

REQUEST FOR RELEASE OF INFORMATION AUTHORIZATION FORM

TO: MSI (Nova Scotia Medical Services Insurance)
PO Box 500
Halifax, NS
B3J 2S1

ATTN: Carol Coutts-Jarrett (Fax: 492-2921)

I, _____, authorize Medavie Blue Cross Care and the MSI Program to release to _____ (*insert either name of patient or designated recipient*) any and all information as to my medical condition, treatment and professional services which relate to any MSI and WCB claims for the period of _____ to _____.

Witness' Signature

Date

Patient's (or Parent/Guardian's Signature)

Date

Patient's Name (Print)

Date of Birth

Patient's Address

Patient's Health Card Number

Old MSI Number (if available)

In order to avoid delays, please ensure this form has been completed correctly and in full.