|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | Consent to Disclose  Personal Information | | | | | | | | |
| INSTRUCTIONS: | | | | | | | | | | | | |
| 1. ­If you’re using this form to provide consent, please complete Parts 1-4 and 6. 2. If you’re using this form to revoke consent, please complete Parts 1 and 5. 3. During the ongoing COVID-19 situation, this form may be returned by fax (780-438-5304) or email ([benefits@asebp.ca](mailto:benefits@asebp.ca)) as a scanned document or as a photo (as long as it’s signed and the image is readable). **Please note that physical signatures are still required on this form.** | | | | | | | | | | | | |
| Part 1 - Identification\**\*Who the information is about* | | | | | | | | | | | | |
| First name: | | | | | Last name: | | | | | | ASEBP ID #: | |
| Mailing address: | | | | | | | | | Birth date (YYYY/MM/DD):      /    / | | | |
| City: | | | | | | Province: | | | | Postal code: | | |
| Home phone #:    -   - | | | | | | | Work or mobile phone #:    -   - | | | | | |
| Email: | | | | | | | | | | | | |
| **Part 2 - Capacity to Provide Consent** | | | | | | | | | | | | |
| Is your dependent child, who is 16 or older, capable of providing consent? Yes (have your dependant complete the rest of the applicable parts of this form)  No\*  N/A \*If your dependent child, who is 16 or older, is incapable of providing consent to the disclosure of their personal information, you may act on their behalf. Their inability to provide consent must be supported through medical or legal documentation, which must be submitted to ASEBP for review and verification. I’ve included medical or legal documentation to support my child’s inability to provide consent | | | | | | | | | | | | |
| Part 3 – Type of Information (Please check all that apply) | | | | | | | | | | | | |
| Select the type of information ASEBP has consent to release. Benefit utilization is a record of the claims submitted and paid for each benefit type, this includes claims submitted by a covered member or a dependant, as well as a service provider (e.g. pharmacist). | | | | | | | | | | | | |
| Extended Health Care utilization | | Dental Care utilization | | | | | | Vision Care utilization | | | | Spending Account |
| Extended Disability Benefits information: | | | | | | | | | | | | |
| Current claim file | | | Past claim file(s); claim time period (YYYY/MM/DD): From      /    /    To      /    / | | | | | | | | | |
| Other: | | | | | | | | | | | | |
| Why is the release of information indicated above being requested?  To answer questions about the plan  Benefit administration  Income tax  Litigation  Other: | | | | | | | | | | | | |

**Part 4 - Release of Information**

|  |  |  |
| --- | --- | --- |
| Indicate to whom ASEBP should release the requested information. This could be a person or an organization (e.g. lawyer). In the case of an organization, please provide a contact name. Please complete all fields below. | | |
| 1. Name: | | Person  Organization |
| Contact name (if information is being sent to an organization): | | |
| Mailing address: | | |
| Home phone #:    -   -     Work phone #:    -   -     Email: | | |
| Method of release:  By phone  In person  In writing  By fax  By email  Consent to remain in place:  Indefinitely  Until (YYYY/MM/DD):      /    / | | |
|  | | |
| 2. Name: | | Person  Organization |
| Contact name (if information is being sent to an organization): | | |
| Mailing address: | | |
| Home phone #:    -   -     Work phone #:    -   -     Email: | | |
| Method of release:  By phone  In person  In writing  By fax  By email  Consent to remain in place:  Indefinitely  Until (YYYY/MM/DD):      /    / | | |
| Part 5 – Consent Revocation | | |
| I would like to revoke the previous consent provided for the disclosure of my personal information to       (name), given on or about       /    /    (date YYYY/MM/DD). | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of person identified in Part 1 or parent/guardian\*\*  \*\* Signature of parent or guardian is only required if the person identified in Part 1 is younger than 16 or is deemed incapable of providing consent. | | |
| Part 6 - Acknowledgement | | |
| I understand that consent is effective on the date this document is signed and remains in effect until it’s revoked. I understand why I have been asked to provide this information to the requestor. I’m aware of the risks and benefits of consenting to or refusing to consent to the disclosure of this information. I’m also aware that I may withdraw this consent at any time by notifying ASEBP in writing. | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | /    / | |
| Signature of person identified in Part 1 or parent/guardian\*\* | Date (YYYY/MM/DD) | |
| Name of signatory: | | |
| \*\* Signature of parent or guardian is only required if the person identified in Part 1 is younger than 16 or is deemed incapable of providing consent.  Consent is being obtained in accordance with sections 7, 8, 9 and 61 of the *Personal Information Protection Act* of Alberta and section 1 of the federal *Personal Information Protection Electronic Documents Act*. Be advised that in order to optimize the services we provide we may use service providers outside Canada to carry out certain functions on our behalf. In such situations, we enter into contracts and/or verify that appropriate privacy and security protocols are in place. If you have any questions regarding the collection, use and disclosure of your personal information, please refer to ASEBP’s Privacy Policy at www.asebp.ca or contact the privacy officer at 780-438-5300. | | |