G | m | s
Group Medical Services

Privacy Release Form
Health and Travel Claims

Please return the completed form to GMS at 2055 Albert Street PO Box 1949 Regina, SK S4P 0E3. Completed forms can also be scanned and sent to info@gms.ca.

Release

I, ______________________________ , give permission to ______________________________ (my "Agent")
INSURED PERSON *(first and last name)* MY INSURANCE BROKER/AGENT

to have access to any and all relevant claims information, including medical records and personal health information related to the adjudication of my

claim number/case ID ____________________ with Group Medical Services ("GMS").
CASE ID/CLAIM NUMBER

By signing this form I acknowledge and understand that information regarding my claim, including personal health information, will be shared between GMS and my Agent. It is my request that my Agent assist me in understanding the claim adjudication procedure and its results. I understand that GMS may involve GMS' sales staff in communications with my Agent and that GMS must share my personal health information with GMS' sales staff in order to assist with resolution of my claim.

Signature of Insured Person	Name of Insured Person *(please print)*	Date *(DD/MM/YYYY)*
X		

For claims enquiries, please contact our Customer Care Centre at 1.800.667.3699 or info@gms.ca.