Consent Form

This form must be completed by the individual who is the subject of the personal information or granting authorization to act on their behalf. If the individual is under the age of 18 a parent or guardian must complete this form. Please complete all sections and submit the original form to Customer Care at Group Medical Services 2055 Albert Street PO Box 1949 Regina, SK S4P 0E3

A. Authorization

GMS Member ID	Date of Birth *(dd/mm/yyyy)*

First Name	Last Name

I _____ hereby authorize Group Medical Services to

❑ disclose my personal information, including my personal health information, as it relates to my benefit plan policy to the following person(s):

OR

❑ deal with the following person(s) with respect to all matters relating to my benefit plan policy. This includes disclosing my personal information.

	First Name	Last Name	Phone Number
1.			
2.			
3.			
4.			
5.			

B. Effective Date

This consent is effective on: (DD/MM/YYYY)	This consent will continue indefinitely unless I indicate an expiry date below. (DD/MM/YYYY)

I understand that this consent may be revoked by me in writing at any time.

C. Signature

Signature **X**	Date (DD/MM/YYYY)

Name of Person Signing *(please print)*

Relationship *(if the subject is under the age of 18)*