The 1986-1990 Hepatitis C Claims Centre
PO Box 2370, Station D
Ottawa (Ontario) K1P 5W5
Canada
Tel: 1 877 434-0944
www.hepc8690.ca

Compensation for Uninsured Treatment/Medication
Authorization for Release of Information by HCV Infected Person or HCV Personal Representative
Strictly Private and Confidential

CLAIMANT PLEASE AFFIX HERE ONE OF THE PREPRINTED LABELS PROVIDED
* **If you do not have the labels, call 1 877 434-0944 for instructions.**

CORRECTIONS ONLY
Write any name, address corrections below, if any corrections are necessary.

I am (check one):
☐The HCV Infected Person **OR** ☐The HCV Personal Representative of the HCV Infected Person

I hereby authorize the Health Plan(s) listed below to disclose/transmit information concerning any uninsured medical expenses that have been claimed **regarding** the HCV Infected Person.

________________________________ D.O.B. ____________
(Name of HCV Infected Person) (DD/MM/YYYY)

For examination by The 1986-1990 Hepatitis C Claims Center.

Name of Health Plan #1		Policy Number	
Telephone Number	Fax Number	City/Municipality	Postal Code
( ) -	( ) -		

Name of Health Plan #2		Policy Number	
Telephone Number	Fax Number	City/Municipality	Postal Code
( ) -	( ) -		

I agree to waive any right of action against any person or institution for providing information in compliance with this authorization.

Dated the _______ day of _____________ 20____

Witness' Signature

HCV Infected Person's or HCV Personal Representative's Signature