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 Costs of Care
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 any treating physician, any care provider, or the health plan(s) listed below to disclose/transmit information concerning any Costs of Care 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		Policy Number	
Telephone Number	Fax Number	City	Postal Code
( ) -	( ) -		

Name of Health Plan		Policy Number	
Telephone Number	Fax Number	City	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