ACM
ACTIVE CARE MANAGEMENT

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO
The Manufacturers Life Insurance Company – Campus Care

I _____authorize and direct any physician, medical practitioner, hospital clinic, other medical or medically related facility, institution or person that has any records or knowledge of my condition, to provide such information to **The Manufacturers Life Insurance Company – Campus Care.**

I understand that The Manufacturers Life Insurance Company – Campus Care may, from time to time, request reports on my medical condition.

Furthermore, Active Care Management, who I authorize to receive all of my physician, medical practitioner, hospital, clinic, and other medical or medically related information and records shall have the right to distribute this information to other parties that are required to review my medical records and information in the process of their review of any insurance claim and /or health benefit claim made by me or on my behalf**.**

Lastly, I understand that if Active Care Management undertakes to consult with other health care providers concerning my pre and post treatment program, that my medical records and information may be evaluated by other health care practitioners. Therefore, I fully consent to the release of any medical information contained therein for that purpose and for any purpose set forth above.

This authorization shall remain in force for 12 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at address below. Alternatively, I may revoke this authorization by sending a written revocation directly to the Providers. I understand that a revocation is not effective to the extent that any of the Providers has relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policy.

I understand that the Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record or that of my unemancipated minor children, the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Date: _____ Insured Signature: _____

Date: _____ Witness Signature: _____

PLEASE RETURN BY FAX 1-519-251-5165, toll free 1-877-432-9226 or Email: travelassistance@active-care.ca
Tel: North America: 1-866-595-7171 Worldwide Collect: 519-251-5178