



Allendale Centre East
Suite 301, 6104-104 Street NW
Edmonton | Alberta | T6H 2K7

CONSENT TO DISCLOSE PERSONAL INFORMATION

INSTRUCTIONS:

1. Complete each section below. Incomplete forms will not be accepted.
2. Return this form to the address above or fax to 780-438-5304.

Part 1 - Identification*

**Who the information is about*

First name: _____ Last name: _____ ASEBP ID #: _____

Mailing address: _____ Birth date (YYYY/MM/DD): ____ / ____ / ____

City: _____ Province: _____ Postal Code : _____

Home phone #: _____ Work or Mobile phone #: _____

Email: _____

Part 2 – Type of Information (Please check all that apply)

Select the type of information ASEBP has consent to release. Benefit utilization is a record of the claims submitted and paid for each benefit type, this includes claims submitted by a covered member or a dependant, as well as a service provider (e.g. pharmacist).

Extended Health Care utilization Dental Care utilization Vision Care utilization Spending Account

Extended Disability Benefits information:

Current claim file Past claim file(s); claim time period: From _____ To _____

Other: _____

Why is the release of information indicated above being requested?

To Answer questions about the plan Benefit administration Income tax Litigation

Other: _____

Part 3 - Release of Information

Indicate to whom ASEBP should release the requested information. This could be a person or an organization (e.g. lawyer). In the case of an organization, please provide a contact name. Please complete all fields below.

1. Name: _____ Person Organization

Contact Name (if information is being sent to an organization): _____

Mailing address: _____

Home phone #: _____ Work phone #: _____ Email: _____

Method of release: By phone In person In writing By fax By email

2. Name: _____ Person Organization

Contact Name (if information is being sent to an organization): _____

Mailing address: _____

Home phone #: _____ Work phone #: _____ Email: _____

Method of release: By phone In person In writing By fax By email

Part 4 - Acknowledgement

I understand that my consent is effective on the date I sign this document and shall continue indefinitely or until ____/____/____ (YYYY/MM/DD). I understand why I have been asked to provide this information to the requestor. I am aware of the risks and benefits of consenting to or refusing to consent to the disclosure of this information. I am aware that I may withdraw this consent at any time by notifying ASEBP in writing through contact information provided herein.

Signature of Person Identified in Part 1 or Parent/ Guardian**

____/____/____
Date (YYYY/MM/DD)

** Signature of Parent or Guardian is only required if the person identified in Part 1 is under the age of 16.

Consent is being obtained in accordance with sections 7, 8, 9 and 61 of the Personal Information Protection Act of Alberta and Schedule 1 of the federal Personal Information Protection Electronic Documents Act. If you have any questions regarding the collection, use and disclosure of your personal information, please refer to ASEBP's Privacy Statement at www.asebp.ca/privacy.html, or contact the Privacy Officer at 780-438-5300 or by email at po@asebp.ca.