



Suite 700 Weber Centre
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CONSENT TO DISCLOSE PERSONAL INFORMATION

INSTRUCTIONS:

1. Complete each section below. Incomplete forms will not be accepted.
2. Read the acknowledgement in Part 4 and sign and date the bottom of the page. If you have any questions regarding the collection, use and disclosure of your personal information, please refer to our website at www.asebp.ab.ca or contact our Privacy Officer at 780-431-4786 or privacy@asebp.ab.ca.
3. Return this form to the address above.
4. This consent is being obtained in accordance with sections 7, 8, 9, and 61 of Alberta's *Personal Information Protection Act*.

Part 1 - Identification

Your name: _____ ASEBP ID #: _____

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

Home phone #: _____ Work phone #: _____

E-mail _____

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 under each benefit. Utilization would include claims submitted by a covered member or a dependent as well as those submitted by a service provider (e.g. pharmacist).

- Extended Health Care utilization
 Dental Care utilization
 Vision Care utilization
 Diagnostic, treatment and/or care information
 Other _____

For what reason should ASEBP release the information indicated above?

- Answering questions about the plan
 Benefit Administration
 Income Tax
 Litigation
 Other _____

Part 3 - Release of Information

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

1. Name: _____ Person Organization

Mailing address: _____ Contact Name: _____

Home phone #: _____ Work phone #: _____ E-mail _____

Method of release: By phone In person In writing By fax By e-mail

Effective date (YYYY/MM/DD): _____ / _____ / _____ Expiry date (YYYY/MM/DD): _____ / _____ / _____ No end date

2. Name: _____ Person Organization

Mailing address: _____ Contact Name: _____

Home phone #: _____ Work phone #: _____ E-mail _____

Method of release: By phone In person In writing By fax By e-mail

Effective date (YYYY/MM/DD): _____ / _____ / _____ Expiry date (YYYY/MM/DD): _____ / _____ / _____ No end date

Part 4 - Acknowledgement

I understand that I may revoke my consent at any time and understand why I have been asked to disclose the information and am aware of the risks and benefits of consenting or refusing to consent to the disclosure.

Signature: _____ Date: _____