1605

Authorizing or Cancelling a Representative Form

Complete this form to authorize the release of personal information to a representative or to cancel an existing representative. Only completed forms will be processed. Retain a copy for your files.

Forward the completed form to the Doctors of BC via scan and e-mail to benefits@doctorsofbc.ca or fax to 604-638-2913.

This authorization will remain in effect until formally cancelled.

Authorization or Cancellation

I, Last Name | First Name and Middle Initial | MSP Number

authorize the release of personal information by the Doctors of BC to the representative named below.

If a **firm**, enter the name of the firm.
If an **individual**, enter the first and last name of the individual.

Representative's name (firm or individual)

If you entered a firm as your representative, and you want to specify a particular individual of that firm, enter that individual's first and last name.

Individual at Firm (optional) First and Last Name

Representative's Address and other contact information

Address:

City | Province | Postal Code

Telephone Number: Area Code | Number

Fax Number: Area Code | Number

Email Address:

Purposes of Authorization

I request that this authorization apply to all information regarding:

Check all appropriate boxes.

- ☐ Insurance
- ☐ Negotiated Benefits (CME,CMPA, CPRSP, PDI, PLP & REAP)
- ☐ Doctors of BC Honoraria / Sessional Payments
- ☐ Income (FFS, Service Contract, Sessional & Rural Locum)
- ☐ T4 and T4A slips
- ☐ Membership

Cancellation date (Complete to cancel only)

I formally request that authorization given to the above representative be cancelled effective:

mmm	dd	yyyy

Signature and date

X _____ Signature

mmm dd yyyy

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TF 1 800 665 2262

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