

Request for Information About a Person and Authorization to Disclose Information to a Third Party

This form is for:

- Persons age 14 or over who wish to obtain information on their eligibility for the Québec Health Insurance Plan and the covered services that they have received
- Holders of parental authority for persons under age 14 or representatives wishing to obtain such information concerning the person that they represent

1- Identity of the person concerned

Last name		First name	
Date of birth	Health Insurance Number	Telephone (daytime) AREA CODE	Ext.
Address (number, street, municipality)			Postal code

2- Identity of the person making the request

<input checked="" type="checkbox"/> Person concerned (go to section 3) <input type="checkbox"/> Holder of parental authority (if the person concerned is under age 14) <input type="checkbox"/> Representative (attach the documents attesting that you are acting on behalf of the person concerned)			
Last name	First name	Telephone (daytime) AREA CODE	Ext.
Address (number, street, municipality)			Postal code

3- Subject of the request

<p>The request covers the period * of _____ to date and the following services</p> <p style="text-align: center; font-size: small;">(for office use only)</p> <input checked="" type="checkbox"/> medical services paid by the Régie <input checked="" type="checkbox"/> pharmaceutical services paid by the Régie (information available only if the person concerned was covered by the Public Prescription Drug Insurance Plan during this period)
<p>During this period, did the person concerned receive services that were covered by one of the technical aid programs administered by the Régie (wheelchair, hearing aid, etc.)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>During this period, did the person concerned receive medical services covered outside Québec?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<input type="checkbox"/> I wish to receive a document confirming the period(s) during which the person concerned was eligible of the Québec Health Insurance Plan.

*No information is available for services covered by the Régie before November 1, 1981.

4- Disclosure to a third party – Identity of the person designated to receive the information

Name (individual, corporate entity or public agency) Assurance Banque Nationale		Reference number (if applicable)
Name of the person designated by the corporate entity or public agency (if applicable)	Telephone (daytime) AREA CODE 1 877 871 7500	Ext
Address (number, street, municipality) 1100 boul. Robert-Bourassa, 5e étage, Montréal, QC		Postal code H3B 2G7

Please note that only the third party will receive the information.

5- Signature or the person making the request

_____ Signature (person identified in section 2)		_____ Date
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Please return the form and the required documents, where applicable, to this address:

Direction générale de l'admissibilité et des renseignements
aux personnes assurées
Régie de l'assurance maladie du Québec
Case postale 6600
Québec (Québec) G1K 7T3
or by fax at 418 682-4080

This form does not constitute a request for access within the meaning of the *Act respecting access to documents held by public bodies and the protection of personal information* (chapter A-2.1). Accordingly, it is not possible to request a review of the decision rendered by Commission d'accès à l'information du Québec.