



Policy No. _____
Identification No. _____

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me or my health, to give to Ontario Blue Cross any such information. A photostatic copy of this authorization shall be as valid as the original.

Dated at _____ this _____ day of _____ 19 _____

Signature of Claimant _____ Address _____

Signature of Witness _____ Address _____

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