New Brunswick / Nouveau Brunswick

New Brunswick Drug Plans / Régimes de médicaments du Nouveau Brunswick

New Brunswick Drug Plans
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Websites: www.gnb.ca/NBPDP
www.gnb.ca/drug plan

Release of Information to Third Party Consent Form

SECTION 1 - Member or Applicant Information

First Name: _____ Last Name: _____

Address: _____

City/Town/Village: _____ Province: _____ Postal Code: _____

Telephone: (___)___-____ Date of Birth: DD MM YYYY

Medicare Number: _____

Plan Identification Number (if available): _____

SECTION 2 - Consent

By signing this form, you are giving the New Brunswick Drug Plans permission to indefinitely share personal information about you with the person you name below. You may cancel this permission at any time by calling the number above.

I, (insert name) _____,
authorize the New Brunswick Drug Plans to release to:

Third Party Information

First Name: _____ Last Name: _____

Telephone: (___)___-____ Date of Birth: DD MM YYYY

☐ All my personal health information

☐ Specific personal health information regarding _____,
for the purpose of _____

X Sign here - Member/Applicant:_____ Date signed: DD MM YYYY

SECTION 3 - Witness Information

Anyone 19 years of age or older may be the witness **except** the individuals listed on this form. By signing below, the witness is attesting that the individuals listed on this form are who they claim to be.

First Name: _____ Last Name: _____

Telephone: (___)___-____

X Sign here - Witness: _____ Date signed: DD MM YYYY

Your personal information is collected, used and disclosed in accordance with the *New Brunswick Right to Information and Protection of Privacy Act* as well as the *New Brunswick Personal Health Information Privacy and Access Act*. For more information, visit www.gnb.ca/healthprivacy.