CONSENT TO SHARING OF INFORMATION

I hereby authorize Dr _____ to submit to the Insurance Corporation of British Columbia (ICBC) the Report identified below ("Report"), which contains medical information related to a motor vehicle accident dated _____. I understand that the information contained in the Report can be used by ICBC in connection with my insurance claim.

☐ Standard Medical Report (CL489)

☐ Extended Medical Report (CL489A)

☐ Other _____

A photocopy or electronic version of this authorization is as valid as the original.

I have read and understood the contents of this document and I hereby consent to the sharing of the Report with ICBC, and the use of my medical information contained therein as indicated above.

_____

Signature

_____

Name *(please print)*

_____

Date: *(mm/dd/yyyy)*

Motor Vehicle Accident Information

Murrayville Family Practice Group **Willoughby Family Practice Group**

ICBC Claim Number: _____ **Have this prior to 1st appointment.**

If you have not called ICBC for your Claim #, call 604-530-7111

Name: _____

Email: _____

Date of accident: _____

Position in vehicle (driver, passenger, front, back) _____

Type of Vehicle: _____

Damage to vehicle: _____

Number of vehicles: _____

Other people in the vehicle: _____

Patient Information:

Brief description of what occurred:

_____

_____

_____

In point form please list injuries (one injury per line):

1. _____
2. _____
3. _____
4. _____
5. _____

In the event you do not pursue this claim with ICBC it is imperative you call our office and inform staff.