

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

This for mis 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

First name

 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

Date of birth	Health Insurance Number	Telephone (daytime) AREA CODE	Ext.		
Address (number, street, municipality)			Postal code		
2- Identity of the per	son making the reques	t			
☑ Person concerned (g	o to section 3)				
☐ Holder of parental au	thority (if the person concerned d	lis under age 14)			
☐ Representative (attack	ch the documents attesting that you	u are acting on behalf of the perso	n concerned)		
Last name	First name	Telephone (daytime) AERA CODE	Ext.		
Address (number, street, municipa	lity)		Postal code		
3- Subject of the rec	uest				
The request covers the period * of to date and the following services					
oxtimes medical services paid by					
□ pharmaceutical services Drug Insurance Plan during this per □ pharmaceutical services □ pharmaceutical	, , ,	ilable only if the person concerned	d was covered by the Public Prescription		
During this period, did the person (wheelchair, hearing aid, etc.)?	concerned receive services that we	ere covered by one of the technica	al aid programs administered by the Régie		
□ Yes □ No					
During this period, did the person	concerned receive medical service	s covered outside Québec?			
☐ Yes ☐ No					

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

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☐ I wish to receive a document confirming the period(s) during which the person concerned was eligible of the Québec Health Insurance Plan.

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

Name (individual, corporate entity of public agency)	Reference number (if applicable)	
Assurance Banque Nationale		
Name of the person designated by the corporate entity or public agency (if applicable)	Telephone (daytime) AREA CODE	Ext
Edward K.A	1 877 871 7500	
Address (number, street, municipality)	Postal code	
800 Saint-Jacques Street, office 43511, Montréal, QC	H3C 1A3	

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

5- Signature or the person making the request			
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	Signature (person identified in section 2)	 Date	

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.

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