



**SCHEDULE "A"**  
**AUTHORIZATION TO PROVIDE MEDICAL INFORMATION**

I, \_\_\_\_\_ (or, I \_\_\_\_\_ parent/guardian of \_\_\_\_\_, a minor) hereby consent to and authorize Manitoba Health to furnish to any representative of \_\_\_\_\_, claim and payment information in Manitoba Health's possession in respect of claims for Medical Services incurred for which I had insurance coverage from \_\_\_\_\_ including physician/hospital name, date of service, and services provided (in-patient, out-patient, physiotherapy, visit, procedure, x-ray or laboratory services).

**ASSIGNMENT OF PAYMENT DUE TO REGISTRANT UNDER THE HEALTH SERVICES INSURANCE ACT**

I, \_\_\_\_\_ (or, I \_\_\_\_\_ parent/guardian of \_\_\_\_\_, a minor) hereby direct Manitoba Health to forward payment to \_\_\_\_\_, for any claims for benefits under the Health Services Insurance Act submitted by \_\_\_\_\_ in respect for medical and hospital services provided outside Canada.

DATED this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Manitoba Health Registration Number      SIGNATURE

\_\_\_\_\_  
Address  
\_\_\_\_\_

\_\_\_\_\_  
Personal Health Identification Number      Telephone

 For Claim inquiries, call **1-800-336-9224** or **819-566-8698**.