



CONSENT TO DISCLOSE TO VETERANS AFFAIRS CANADA

AGMEDICA BIOSCIENCE INC.
229 St. Clair Street, Suite 208 | Chatham, ON N7L 3J4
t. 1-844-5MY-CARE f. 1-866-927-8847
e. clientcare@agmedica.ca www.agmedica.ca

CONSENT TO DISCLOSE PERSONAL INFORMATION TO VETERANS AFFAIRS CANADA (VAC)

Pursuant to the Personal Information Protection and Electronic Documents Act, (PIPEDA)

I, _____ (the client), authorize AgMedica Bioscience Inc., to disclose my personal information, consisting of Medical Document(s) and Registration Form(s) to be transmitted to Veterans Affairs Canada (VAC).

- I understand the purpose for disclosing this personal information to Veterans Affairs Canada is to assist me in obtaining reimbursement and any other benefits that I may be eligible for from VAC.
- I understand that this consent is valid for the duration of the Medical Document submitted by the Client, unless I withdraw my consent earlier by sending a written request to AgMedica's Privacy Officer at: ClientCare@AgMedica.ca or by sending my request to AgMedica Bioscience Inc., 229 St. Clair Street, Suite 208, Chatham, ON., N7L 3J4
- I understand that withdrawal of my consent will end further disclosures of my personal information but will not be retroactive.

DISCLAIMER

- I understand that if Veterans Affairs Canada (VAC) does not approve my application, I would be responsible for the full payment of any product(s) that I ordered.

CLIENT INFORMATION

Name: _____ Telephone #: _____

Address: _____

Veterans Affairs Canada Health Benefit Card Number (K Number): _____

Signature: _____ Date (MM/DD/YYYY): _____

CONFIDENTIAL

The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

AGMEDICA BIOSCIENCE INC.

MAIL COMPLETED DOCUMENT TO: 229 St. Clair Street, Suite 208 | Chatham, ON N7L 3J4

OR FAX TO: 1-866-927-8847

OR SCAN & EMAIL TO: clientcare@agmedica.ca

CONSENT TO DISCLOSE TO VETERANS AFFAIRS CANADA | AGMEDICA