INJURED WORKER'S AUTHORIZATION OF A REPRESENTATIVE

Toll Free 877-787-0622
www.mpoalberta.ca
#210A, 10405 Jasper Ave
Edmonton AB T5J 4R7

MPO
Medical Panels Office

Part 1: Instructions and Important Information

Use of This Form:

This form is only to be used when a worker wishes to authorize a "Formal" or an "Informal" representative to assist with their claim.

Definition of Formal and Informal Representatives:

A formal representative may access information about your claim verbally, in writing, and/or in person. They have authority to make decisions on your behalf, can request a copy of your claim file, and will receive a copy of correspondence sent to you.

An informal representative is allowed to provide and/or receive information about your claim verbally through contact with MPO employees. They do not have authority to make decisions on your behalf, cannot request a copy of your claim, and will not receive a copy of correspondence sent to you.

Your Responsibilities:

It is your responsibility to ensure that authorizations are properly managed. As such, changing or cancelling of any authorization must be submitted in writing.

How Many Representatives Can I Have?

To ensure that your information is disclosed to the individual you have authorized, one formal and one informal representative are permitted. If you already have a formal or informal representative in place, filling out this form for the same type of representative will replace your existing agreement.

Any Questions?

Please contact the Medical Panels Office directly at the phone number or email below.

Please return completed form to:

Fax: 780-424-6352
Phone: 825-468-4251
Toll Free: 1-877-787-0622
Email: mpo@gov.ab.ca

Mail: Attn: Medical Panels Coordinator
Medical Panels Office
#210A, 10405 Jasper Avenue
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Part 2: Instruction to the Medical Panels Office

A: Injured Worker Information:

Injured Worker's *Surname*	*First Name*	*Initial*	WCB Claim Number	Date of Birth *(Year / Month / Day)*
Address *Street*	*City/Town*		*Province*	
Suite	Postal Code	Telephone Number	Fax Number	

B: Representative Information:

I authorize (*check only one box)*

- ☐ A person to act on my behalf, or
- ☐ A company to act on my behalf

This representative is (*check one box only)*

- ☐ Formal — A formal representative may access information about your claim verbally, in writing, and/or in person. They have authority to make decisions on your behalf, can request a copy of your claim file, and will receive a copy of correspondence sent to you.
- ☐ Informal — An informal representative is allowed to provide and/or receive information about your claim verbally through contact with Medical Panels Office employees. They do not have authority to make decisions on your behalf, cannot request a copy of your claim, and will not receive a copy of correspondence sent to you.

Full Name of Person or Company			
Address *Street*	*City/Town*		*Province*
Suite	Postal Code	Telephone Number	Fax Number

C: Scope / Representative:

The above named representative is authorized to represent me:

- ☐ With respect to all past and present claims
- ☐ With respect to claim file (s), Claim number _____

D: Validity Period:

Indicate the expiry date of this authorization, if no expiry date is provided in the box, then this authorization is valid until cancelled in writing.

Authorization Expiry Date:

E: Signature & Acknowledgment of the Injured Worker's Responsibilities:

I, the undersigned, acknowledge that I understand my responsibilities in relation to appointing a representative.

Injured Worker's Signature

Printed Name

Date (*yyyy-mm-dd*)