

MEDICAL INFORMATION AUTHORIZATION

FROM:

I HEREBY AUTHORIZE any hospital, physician, medical attendant, nurse, technician or others, to furnish any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, and photostatic copies of all hospital or medical records to:

DISABILITY CLAIMS ADVOCACY CLINIC
Allison Schmidt
4047 Windsor Park Bay
REGINA, Saskatchewan
S4V 3B1

I HEREBY WAIVE, for the purpose of such report, any privilege I may have regarding secrecy of medical information and release and discharge each examining physician and their staff of all claims for any damages I may sustain resulting from any such report give to my above named firm.

I HEREBY REQUEST you not to disclose any such information to any insurance adjuster or any other person without written authority from me to do so. I hereby revoke all previous authorizations give for the release of medical information for any reason or purpose whatever. Your full cooperation with my advocate is requested.

I AGREE that a photostatic copy of this Authorization shall be considered as effective and valid as the original.

DATED at _____, _____, this _____ day of _____, 2010.

Witness

Claimant