FINANCIÈRE SISIP FINANCIAL
A division of CFMWS
Une division des SBMFC

Authorization to Release Medical Information

Group Policy # 901102

Manulife

Claim No. _____
(Manulife Office Use only)

1. MEMBER INFORMATION

Service Number (SN)	Rank	Surname	First Name	Initials

2. SIGNATURE BLOCK

I hereby authorize all physicians and persons who have attended myself and all hospital, institutions, and government authorities to furnish, to Manulife and/or SISIP Financial, all information in their possession or within their knowledge respecting myself.

I understand that, during the course of their investigations, Manulife and/or SISIP Financial will need to gather and exchange certain information about me, including any information, records or other data concerning me, my medical history and treatment, and my past and present income, employment, education and training (collectively called “Personal Information”).

My Personal Information may be used for the following purposes, where Manulife and/or SISIP Financial deem it necessary for:

- the evaluation of this or any other claim for benefits or applications for insurance that I may have with SISIP Financial;
- administering the policy under which my claim has been made;
- medical case study or review.

I therefore authorize Manulife, SISIP Financial and the following persons, institutions and organizations, to provide to and exchange with each other, any of my Personal Information which they have in their possession or control:

- any physician, health care practitioner, hospital, clinic, pharmacy or other medical facility or provider of health care or treatment:
- any provincial health insurance plan, insurance company, reinsurer;
- any insurance broker or benefit plan administrator, my employer or former employer and any of their agents performing services relating to any employee benefits;
- any federal or provincial government agency, department or organization;
- any investigative or security agency, personal information agent or any other person, agency or institution having my Personal Information.

I understand that any Personal information that is provided, or which Manulife and/or SISIP Financial has collected, will be kept by Manulife and/or SISIP Financial in a confidential file, which will be disclosed only to Authorized Individuals. Authorized Individuals include employees of Manulife and/or SISIP Financial and other persons (corporate or individual), firms or agencies engaged by Manulife and/or SISIP Financial, in the performance of their duties, as well as persons to whom I have granted access in writing, or to any other person authorized by law.

I understand that where Manulife and/or SISIP Financial has obtained sensitive medical information from someone other than my physician, Manulife and/or SISIP Financial will only release such information through my physician.

I understand and agree that this authorization shall continue as long as the claim for which this authorization has been completed exists, or services for this claim are required from Manulife . A copy of this authorization shall be as valid as the original.

The information provided on this form is protected from unauthorized disclosure under *Canada’s Privacy Act* or *Personal Information Protection and Electronic Documents Act* and is available to you upon request.

_____ _____

Member’s Signature Day Month Year