AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of my personal information, held under the:

MANITOBA FOOD AND COMMERCIAL WORKERS DENTAL PLAN

To _____ Address _____
(Name of Person)

_____

☐ without limitation.

☐ with the limitations specified below:

_____

_____

_____

_____

For the following purpose:

_____

_____

☐ This authorization will be in effect for _____ days from the date shown below.

☐ This authorization is without time limits.

I understand that all personal information will be kept confidential and secure and will be released only for the purpose(s) identified herein, over and above the other purpose(s) to which I have agreed in other Plan documentation.

Member Name: _____
(First) (Middle) (Last)

Member S. I. N.: _____ Birth Date: _____
day/month/year

Member Signature: _____ Date: _____

Witness Name: _____
(First) (Middle) (Last)

Witness Signature: _____ Date: _____