

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, [name] _____

AUTHORIZE [name of doctor or hospital releasing information] _____

TO RELEASE the following information:

One copy of all clinical and medical records of (name of claimant) _____
_____ born on _____, 19____
and residing at _____
in the possession of [name of doctor or hospital] _____
_____ including all handwritten or typewritten notes, test results and consultations but excluding x-rays,
relating to any admission or treatment on or after the _____ day of _____ (month)
_____ (year) to the present.

I understand that these records may contain information about my medical history and other confidential information and hereby authorize their release.

I consent to the use of this information only for the administration of my claim for compensation for injuries from infection from Salmonella *enteritidis*.

I hereby release the person or hospital named in this release, its employers and agents, from any and all claims whatsoever which may arise as a result of the release of this information.

PLEASE SEND MY RECORDS TO:

**Sovereign General Insurance Company, Attn: Linda Westerlund
1400 – 1095 West Pender Street
Vancouver, B.C. V6E 2M6**

Telephone: (604) 602-8300

Claims Toll Free: 1-800-665-3993

Claims Fax: (602) 602-1057

Toll Free: 1-800-663-1924

Fax: (604) 681-4303

DATED this _____ day of _____, 2002.

WITNESS:

Signature

Name

Address

)
)
)
) _____
) Patient's or Representative's Signature
) (Parent/Guardian)
)
) _____
) (If a representative, please state relationship)
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