AUTHORIZATION FOR THE DISCLOSURE OF MEDICAL INFORMATION

La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, P.O. Box 1500, Quebec QC G1K 8X9
418 644-4200 ou 1 800 463-4856 • Fax: 418 646-1313 • adm.collectif@lacapitale.com

GROUP NO.	EMPLOYER NO.	IDENTIFICATION NO.

1 – PARTICIPANT'S IDENTIFICATION

FAMILY NAME		FIRST NAME	
ADDRESS NO. STREET	APT.		PHONE AT HOME
CITY	POSTAL CODE		PHONE AT WORK

2 - AUTHORIZATION

TO THE MEDICAL DIRECTOR

I authorize La Capitale Civil Service Insurer Inc. to contact the doctor mentioned hereafter in order to explain the decision for my group insurance request.

Doctor's name ______________________________

Address ______________________________

____

____

Postal code ______________

Insurance request for:

Name ______________________________

Address ______________________________

____

____

Postal code ______________

Date of birth ______________

3 –SIGNATURE OF THE PARTICIPANT

Signed in ______________, on the ______ day of ______________ 20 ____.

______________________________ Signature of the participant

______________________________ Signature of the witness

Each employer may reprint this form for its needs.

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