La Capitale

La Capitale Civil Service Insurer Inc.

MEDICAL AUTHORIZATION

625 Jacques-Parizeau St.
P.O. Box 16040
Quebec QC G1K 7X8
418 644-4106 or 1 888 703-4480
Fax: 418 643-8597 or 1 866 375-9780

To be filled in by the claimant

Last name and first name of deceased or individual on disability

Last name _____ First name _____

I, the undersigned, hereby authorize you to provide the Insurer's Medical Director with a certified true copy of the complete medical records and any information concerning medical treatment given to the above-named person including consultations, treatments, surgeries, etc.

The following persons or organizations are authorized to provide the above information:

a. physician
b. medical specialist
c. chiropractor
d. psychologist
e. pharmacist
f. optometrist
g. any individual, according to the law bound by Professional Secrecy
h. any establishment where such persons practise
i. any establishment within the meaning of the Act Respecting Health Services and Social Services
j. any government body or agency
k. any compensation board
l. any insurance company
m. any other organization, institution, establishment or individual holding records or information on the above individual:
   - Régie des rentes du Québec
   - Régie de l'assurance maladie du Québec
   - Commission de la santé et de la sécurité du travail
   - Commission administrative des régimes de retraite et d'assurances
   - Société de l'assurance automobile du Québec
n. the employer of the deceased or individual on disability

To be filled in and signed by the claimant

I authorize the request of information in my capacity as _____

(Specify: policyholder, insured, beneficiary, legal heir, executor, etc.)

Policy Number(s) _____

Signed at _____ this ____ day of _____ 20 ____.

Witness _____ Signature of claimant _____

A copy of this authorization shall have the same force and effect as the original.