SIMON FRASER UNIVERSITY
Human Resources Department

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Contract: ASO83064

Social Insurance No: ________________________

Date: ________________________

I, ____, hereby consent to and authorize Manulife Financial to release to my employer, Simon Fraser University, any and all medical documentation provided by my physicians, hospitals, clinics, other medical or medically related facilities submitted with respect to my long term disability claim commencing on or about ________________________, 20___. I fully understand that this information will be kept confidential.

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Signature

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Address

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Telephone Number