LiUNA!care LOCAL 183
BUILDING HEALTHY FUTURES

AUTHORIZATION TO RELEASE PERSONAL INFORMATION

Send to: LiUNAcare Local 183 | 1263 Wilson Avenue, Suite 205 | Toronto, ON M3M 3G2
P: 416.240.7487 | F: 416.240.7488 | w: www.liunacare183.com | e: info@liunacare183.com

A. Member Information *(Please Print)*

Last Name First Name	Gender ☐ Male ☐ Female
Address	Date of Birth (yyyy/mm/dd)
Town/ City Prov. Postal Code	Country
Member Advantage Benefit Card ID Number (last 10 digits)	*Social Insurance Number (SIN) - ONLY if no Member Advantage Benefit Card ID*
Email Address	Phone #
Marital Status ☐ Married ☐ Common-Law ☐ Single ☐ Separated ☐ Divorced ☐ Widow	Cell #

B. Person of Authorization

In the boxes below, please list the relationship status, name and birth of all individuals

Name of Authorized	Relationship to Member (spouse, child etc.)	Birth Date Day	Month	Year	Contact Information

C. Disclosure Member Authorization

I am a member of the LiUNA Local 183 Members' Benefit Fund and I do hereby request that the LiUNAcare Local 183 office release, in writing, details of my personal health related information. I hereby consent to the disclosure of my personal information to the following individuals listed above.

As the authorized representative receiving the above members' personal information, agree to keep the personal information entrusted to me private and confidential.

This consent is valid: *(Choose ONE only)*

☐ For this request only

☐ For a period of one year

☐ Until I withdraw the consent or cease to be a member/beneficiary of the fund

Member Name: _____ Member Signature: _____

(Please Print)

Date: _____

Please complete, print, sign, and return by fax at 416.240.7488 **OR** email to info@liunacare183.com