

AUTHORIZATION TO RELEASE PERSONAL INFORMATION

Send to: LiUNAcare Local 183 | 2100 - 200 Labourers Way | Vaughan, ON L4H 5H9
 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			Contact Information
		Day	Month	Year	

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: _____