SUTTON
SPECIAL RISK

## Authorization to Disclose Information

Policy No./Certificate No.:_____

I,_____ hereby authorize any hospital, physician, medical practitioner, clinic, other medical or medically related facility, pharmacy, insurance or reinsurance company, Government Agency, Ministry of Health & Long Term Care, to disclose or furnish to **Sutton Special Risk**, its subsidiaries or representatives, any and all information with respect to any illness or injury, medical history, consultations, prescriptions, treatments or benefits, and copies of all applicable records that may be requested. I also authorize my employer to disclose all information needed to process my claim.

The information provided to **Sutton Special Risk**, its subsidiaries or representatives, is to be used solely for the administration of claims(s) as captioned above. The information collected may be exchanged with the above mentioned parties when relevant and necessary for the purposes of assessing this claim. Additional information may be obtained by referring to the Sutton Special Risk privacy policy, which can be found at www.suttonspecialrisk.com or by calling 1-800-461-3292 and asking to speak to the Privacy Officer.

I know that I may request to receive a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for two years from the date shown below. I understand that I may withdraw my consent at any time, in writing, subject to legal or contractual restrictions and reasonable notice.

| _____ | _____ | _____ |
|---|---|---|
| Date (dd/mm/yy) | Claimant's Signature | Claimant Print Name |
| _____ | _____ | _____ |
| Date (dd/mm/yy) | Witness Signature | Witness Print Name |

Note: A true copy of this Authorization is available to the Claimant or his/her authorized representative at any time, upon request.

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