



APPOINTMENT OF REPRESENTATIVE AND AUTHORIZATION FOR THE RELEASE OF INFORMATION

Claim Number: _____

I, _____, (customer name) was injured in an automobile accident on _____ ("the accident") and have made a claim for compensation to the Manitoba Public Insurance Corporation ("MPI").

I authorize MPI to release any and all information that can be legally released to my representative, including medical reports and any other personal information or personal health information that I would be entitled to receive under the provisions of The Manitoba Public Insurance Corporation Act, The Freedom of Information and Protection of Privacy Act, and The Personal Health Information Act, and for this purpose, the original of this authorization or a photocopy of it shall constitute sufficient authority for the release of the information.

I authorize MPI and my representative to collect personal information and personal health information relating to my claim on my behalf, and I authorize my representative to disclose this information to MPI.

I authorize MPI and my representative to disclose the personal information, or personal health information, collected on my behalf to any health care practitioner from whom MPI or my representative is seeking an opinion relating to my claim.

I understand that information collected on my claim may be shared with other departments within Manitoba Public Insurance for the purpose of administering its driver's licensing and vehicle registration programs, and its other insurance programs.

I appoint _____ (representative name) to act upon my behalf and to assist me in all matters relating to my claim for compensation arising out of the accident.

This authorization shall be valid for a period of two years from the date of signature, unless earlier revoked, or changed by me, in writing.

Signature of Customer

Date (dd/mm/yy)

To be completed by Representative:

I _____ (representative name) agree to act as the representative for _____ (customer injured in the accident name). The following is my contact information:

Address: _____

Date of birth: _____

Daytime phone number: _____

Signature of the Representative

Date (dd/mm/yy)

Please return the completed form to:

Manitoba Public Insurance
Injury Claims Management
P.O. Box 6300, Winnipeg, MB R3C 4A4
Or Fax to Number: 204-954-5332