Request for information from medical records

Sun Life Financial

Policy no.	Evidence no. (For H.O. use only) E #

Proposed insured's first name	Middle initial	Last name	Date of birth (dd-mm-yyyy)
			– –

I authorize and request _____ hospital to give the Sun Life Assurance Company of Canada full information about me including case history, treatment, lab reports, ECG's, x-rays, consultations as an in-patient or as an out-patient on or during:

Dates attended for the above			
First name	Middle initial	Last name	Date of birth (dd-mm-yyyy) – –
Address (street number and name)			Apartment or suite
City	Province	Postal code	

I acknowledge and agree that in complying with this request, the _____ hospital does not assume any liability to me of any kind.

Name (please print)			Relationship if not patient
Location signed (city)	Location signed (province)	Date (dd-mm-yyyy) – –	Signature X

A copy of this authorization is as valid as the original.

Please send original only.