Thalidomide Survivors Contribution Program
Consent for Release of Medical Information

To: ____
(doctor, hospital or health care professional)

Address: ____

City: ______________________________ Province: ______________________________

Postal Code: ________________________ Telephone: ____________________________

Fax: ______________________________

I, ____, HEREBY AUTHORIZE AND DIRECT you to provide to Crawford Class Action Services, a division of Crawford & Company (Canada) Inc:

a complete copy of my medical file including clinical notes, records, opinions, test results, x-rays reports and any and all documents with respect to the physical condition and treatment of Thalidomide ("condition") and any other illness, without limitation whatsoever for the prior eighteen (18) months since my last healthcare visit. I also authorize for you and request that you be responsive to discussing, disclosing information, and providing opinions about my health by telephone calls or in writing to the Administrator and/or its agents for the purposes of assessing my disability level under the Thalidomide Survivors Contribution Program.

DOB (mm/dd/yyyy): ______________________________

Provincial Health (Insurance) Card Number: ____________________

I understand that this information:

- will be used only to assess my disability level in order to determine what my ongoing yearly payment will be under the Thalidomide Survivors Contribution Program;
- is confidential and, except as required by law, will be used and disclosed only for the purpose of administering the Thalidomide Survivors Contribution Program.

Patient Name (please print)	Witness Name (please print)
Patient Signature	Witness Signature
Date (mm/dd/yyyy)	Date (mm/dd/yyyy)

Return by mail to:

Thalidomide Survivors Contribution Program
c/o Crawford Class Action Services
3-505 133 Weber St N
Waterloo ON N2J 3G9