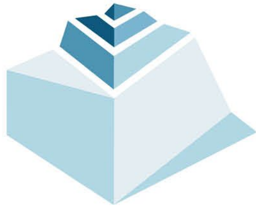

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Please complete this form and return it to the Teachers' Pension Plan Corporation.

Section I – MEMBER INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL
MCP #	HOME MAILING ADDRESS	
DATE OF BIRTH		

Section II – EMPLOYMENT INFORMATION

NAME OF EMPLOYER

Section III – DECLARATION

I, __________________________ , agree to permit my attending physician(s) listed below and/or the Medical Records Department of the below hospitals to release any medical information requested to Dr. C. McVicker, (or his designate), Medical Advisor to the Teachers' Pension Plan Corporation, pertaining to my application for a disability pension. Any costs associated with the release of medical information from my doctor(s) to the Medical Advisor will be borne by me. I understand that this information will be treated confidentially.

To help ensure correct identity and prompt delivery of medical information, my Date of Birth and MCP# are provided above.

ATTENDING PHYSICIANS – if the full name and phone number is not provided it may result in processing delays.

Name	Phone
Name	Phone
Name	

HOSPITALS

Hospital Name	Phone
Hospital Name	Phone

MEMBER SIGNATURE	DATE SIGNED

Section IV – WITNESS

WITNESS SIGNATURE	DATE SIGNED