CONSENT TO RELEASE OF INFORMATION

I _____ hereby authorize **JF Insurance Agency Group Inc.** to act on my behalf all information and documentation, including medical and other personal information, provided by me or obtained by **JF Insurance Agency Group Inc.** from third parties (collectively, " records") regarding any matter for which I may make a claim to **JF Insurance Agency Group Inc.** under a policy of insurance. I understand that the purpose for the provision of records to and the discussion of records is to enable **JF Insurance Agency Group Inc.** and insurers to determine whether and to what extent my claim may be covered by insurance and to facilitate communications about my claim. This authorization takes effect on the date set out below and may be revoked by me at any time in writing. If this authorization is revoked before the provision of records to and the discussion of records, the assessment and processing of my claim may be delayed.

A copy of this authorization received by **JF Insurance Agency Group Inc.** shall be as effective and valid as the original.

Date: _____ Insured's name: _____
(dd/mm/yy) (Please Print)

Signed: _____ _____
(Insured or authorized representative) (Print name of authorized representative)

_____
(Relationship to Insured)

Please indicate to whom payment should be made: _____