Canada Revenue Agency | Agence du revenu du Canada

**PROTECTED WHEN COMPLETED - B**

**PART 1** (Authorization to Release Medical Information)

**TO BE COMPLETED BY THE PATIENT**

PATIENT / CLIENT NAME:

Our Account Number: (please quote this number on all correspondence)

ADDRESS: _____

DATE OF BIRTH: _____ (dd/mm/yyyy) TELEPHONE NUMBER: _____

I HEREBY AUTHORIZE: (Name of physician, address and phone number) _____ to complete part 2 and provide the authorized officials at Canada Revenue Agency (CRA) the medical information and employability requested below relating to my medical condition, based upon your examination(s) of me and upon medical information contained in the records pertaining to me. This information will be used to help administer the collection process with CRA.

DATE: _____ (dd/mm/yyyy) SIGNATURE: _____

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