

**INDIVIDUAL'S CONSENT TO DISCLOSURE
OF PERSONAL INFORMATION**

I, _____, Social Insurance Number: _____
(name of individual) *(optional)*

Date of Birth: _____, residing at: _____

(full address), Telephone no: _____

do hereby authorize WorkSafeBC (the Workers' Compensation Board of BC) to disclose my personal information from the following records:

(identify records)

to: _____
(specify name and address of the body or person authorized to receive and/or use this information)

to be used only for the purpose of: _____

This consent shall be and remain in effect for 2 years unless otherwise specified or revoked in writing prior to that date.

(signature of individual giving consent) _____
(date)