



AUTHORIZATION FORM

Eligible Person (Applicant)

Last Name _____ Given Name(s) _____

Relationship to Person Named on Copy Requested (i.e. myself, parent, spouse, etc)

Street Address _____

City _____ Province _____

Postal Code _____ Phone Number _____

Authorized Individual (i.e. Metis Nation Saskatchewan)

Last Name _____ Given Name(s) _____

Metis Nation - Saskatchewan Registry
Organization Name _____

Street Address _____ 310 20th Street East _____

City _____ Saskatoon _____ Province _____ Saskatchewan _____

Postal Code _____ S7K 0A7 _____ Phone Number _____ 306-343-8391 _____

I hereby waive, for the purpose of such document, any privilege I may have regarding privacy of information and release and discharge eHealth Saskatchewan to whom this release may be directed of all claims for any damages I may sustain resulting from any such report given to the above-named party.

I further declare that a photocopy of this authorization shall be of the same force and effect as an original signed copy.

Date _____

Signature of Eligible Person _____