

Eligible Person

First Name	_____	Street Address	_____
Middle Name	_____	City	_____
Last Name	_____	Province	_____
Relationship to Person Named on Certificate / Health Card	_____	Postal Code	_____
		Phone Number	_____

Authorized Individual

First Name	_____	Organization Name	_____
Middle Name	_____	Street Address	_____
Last Name Relationship to Eligible Person	_____	City	_____
		Province	_____
		Postal Code	_____
		Phone Number	_____

Document Requested

Birth	Death	Marriage	Health Card
Certificate	Certificate	Certificate	Health Card
Certified Copy	Certified Copy	Certified Copy	

I hereby waive, for the purpose of such document, any privilege I may have regarding secrecy 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 originally signed copy.

Dated at _____ in the Province of _____ this _____ day of _____, 20____.

Signature of Eligible Person