



Worker's Authorization For Release Of Information – FORM B

Print, complete and submit this form by mail, fax or in person to:

P.O. Box 757, 14 Weymouth Street, Charlottetown, PE, C1A 7L7
www.wcb.pe.ca

Phone: (902) 368-5680
Fax: (902) 368-5696

| | |
|----------------|---------------|
| Case ID#: | |
| Worker's Name: | Phone Number: |
| Address: | City: |
| Province: | Postal Code: |

I hereby authorize the Workers Compensation Board to discuss my claim with the following named authorized representative(s). I understand this authorization will remain in effect until I notify the WCB that it is no longer in effect.

| | |
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| 1. | |
| 2. | |
| 3. | |
| 4. | |

| | |
|---------------------|--|
| Worker's Signature: | |
| Date Signed: | |

Personal information on this form is collected in accordance with section 31 of the *Freedom of Information and Protection of Privacy Act* for the purpose of administering claim file releases. For further information about the collection of personal information, please contact the Workers Compensation Board's FOIPP Coordinator at P.O. Box 757, Charlottetown, PE, C1A 7L7 or telephone (902) 368-5680.

Case files for workers will be released in accordance with section 83 of the *Workers Compensation Act* and the Workers Compensation Board Policy, POL-04, Access To Information – Worker Claim Files.

Do not email sensitive information.