

THE  
**Great-West Life**  
ASSURANCE COMPANY



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I \_\_\_\_\_, HEREBY AUTHORIZE THE GREAT-WEST LIFE  
ASSURANCE COMPANY TO RELEASE ALL MEDICAL INFORMATION FROM MY FILES TO MY ATTENDING PHYSICIAN.

Doctor's Full Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_