CONSENT TO RELEASE OF INFORMATION

I _____hereby authorize **JF Insurance Agency Group Inc**. to act on my behalf all information and documentation, including medical and other personal information, provided by me or obtained by **JF Insurance Agency Group Inc**. from third parties (collectively, "records") regarding any matter for which I may make a claim to **JF Insurance Agency Group Inc**. under a policy of insurance. I understand that the purpose for the provision of records to and the discussion of records is to enable **JF Insurance Agency Group Inc**. and insurers to determine whether and to what extent my claim may be covered by insurance and to facilitate communications about my claim. This authorization takes effect on the date set out below and may be revoked by me at any time in writing. If this authorization is revoked before the provision of records to and the discussion of records, the assessment and processing of my claim may be delayed.

A copy of this authorization received by **JF Insurance Agency Group Inc**. shall be as effective and valid as the original.

_____ _____
Name of Insured Signature of Insured

DD / MM / YYYY
Date of Signature

_____ _____
Name of Authorized Representative Relation to Insured

Insured is authorizing payment may payable to

_____ _____
Name of Payee Relation to Insured