REPRESENTATIVE AUTHORIZATION

By signing this form, I am designating the person named below to act as my representative on my appeal before the Manitoba Health Appeal Board. I am also authorizing the release and/or sharing of my personal information and personal health information concerning my appeal to my named representative. Please provide the following mandatory information and signatures.

NOTE: The signature below MUST be of the person who the appeal is about, the "Appellant".

Date: _____

Name (print):_____ **Signature:** _____

Personal Health Information Number (PHIN): _____
(9-digit number)

A WITNESS must be a **"third party"**, not the Appellant or the Representative.

Witness (print):_____ **Signature:** _____

Telephone Number(s): _____

Address: _____

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Name of Representative: _____

Relationship to Appellant: _____

Preferred pronoun/s (optional) _____

Address & Postal Code: _____

Telephone Number(s): _____

E-mail: _____**Signature:** _____

Please mail, e-mail, fax or deliver this completed form with the Notice of Appeal to the Manitoba Health Appeal Board at the following address:

Manitoba Health Appeal Board
102 – 500 Portage Avenue
Winnipeg MB R3C 3X1
Phone: (204) 945-5408
Fax: (204) 948-2024*
E-mail: appeals@gov.mb.ca