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AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION		
INSTRUCTIONS: Please do not forget to sign and date this form.	**IMPORTANT:** This form will be returned if incomplete or unsigned.	**COMPLETED FORM:** Can be mailed, faxed, or emailed to admin@quikcard.com.

I, ____, authorize Quikcard Solutions Inc.
(Name of Primary Cardholder)

("Quikcard") to disclose any personal information, including personal health information, in its files

about: ____
(Names of people whose information may be disclosed)

to ________________________________ for policy administration purposes.
(Name of person to receive information)

This authorization is effective immediately. I understand that I may revoke this authorization at any time by notifying Quikcard but such revocation will not have any effect on personal information disclosed by Quikcard before it receives such revocation.

Cardholder Number: ________________________________

Group Number: ________________________________

Signature: ________________________________

Date: ________________________________