AUTHORIZATION FORM FOR THE ENHANCED DISABILITY MANAGEMENT PROGRAM

This Authorization Form is to be used when the disability management service provider is the Employer.

PURPOSE

Purpose of the Authorization:

The purpose of this authorization is to allow_____Health Authority to collect, use and disclose information about me that is necessary for the operation of the Enhanced Disability Management Program ("EDMP"), including compliance with Human Rights Legislation (the duty to accommodate), my continuation of or return to work, and to help process any disability benefits[1] I may be entitled to.

The purpose of this authorization is also to protect my right to privacy by restricting the collection, use and disclosure of my information consistent with the Confidentiality Policy that forms part of the EDMP. My information will be maintained in a secure and confidential manner under the Freedom of Information and Protection of Privacy Act (FIPPA) or Personal Information Protection Act (PIPA) (whichever applies to my circumstance). I may rescind this consent in writing at any time.

This authorization will assist the Health Authority and my Union that are party to the EDMP to:

- Determine if other medical or rehabilitation processes would be beneficial
- Develop a Case Management Plan
- Determine the type of work suitable to my medical restrictions
- Confirm the anticipated date of my safe return to work or resumption of certain duties

I understand that this authorization form is **not** an application for disability benefits (e.g. WorkSafe BC, LTD, etc.).

AUTHORIZATION TO ACCESS INFORMATION *(To be completed by Employee)*

Authorization to My Health Care Providers:

I authorize my health care provider(s)[2] to disclose to the Disability Management Professional ("DMP") of_____Health Authority, my personal information[3], including my medical information[4] that is necessary for the delivery of disability management services to me in relation to this injury or illness.

Authorization to the Trustees of the Healthcare Benefit Trust (HBT) and their agent Great West Life Assurance Co. (GWL):

If I make a claim for LTD benefits, I authorize HBT and its agent GWL to exchange with _____Health Authority my personal information, including my medical

[1] "disability benefits" are benefits provided by Work Safe BC, and Great West Life.
[2] "health care provider" means a physician, therapist, or other medical practitioner who has or will examine, diagnose or treat me with respect to the illness or injury for which the disability management services may be provided before or during my participation in the Enhanced Disability Management Program.
[3] "personal information" is information about me and includes medical information.
[4] "medical information" is information about me in the possession of a health care provider that relates to the diagnosis or treatment for the illness or injury for which disability management services may be provided.

information, to the extent that the exchange is reasonably necessary for the processing and administration of my LTD claim at GWL and the management of rehabilitation programs, medical interventions and return to work plans at_____Health Authority.

Authorization to the DMP of_____Health Authority:

I authorize the DMP of_____Health Authority to disclose my personal information, including my medical information, to the following parties:

a. My health care providers;
b. Representatives of my union, designated to represent the Union in the EDMP;
c. Employees of the_____HA working with the DMP to deliver disability management services to me in relation to this injury or illness;
d. HBT and their agent GWL,

to the extent that this disclosure is necessary for my ongoing treatment and/or the effective delivery of disability management services to me.

I further authorize the DMP of_____Health Authority to disclose necessary non-diagnostic information[5] as follows:

a. to my manager/designate for the purpose of stay at work or graduated return to work planning and implementation;
b. designated HR/LR personnel if I require an accommodation.

In the event that additional information beyond the scope of this consent needs to be shared with my manager/designate and/or the designated HR/LR personnel in order to facilitate my safe return to work or an accommodation, a meeting will be held between myself, my union representative/DM/HR rep and an additional authorization will be obtained.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL THE EARLIER OF MY RETURN TO REGULAR EMPLOYMENT OR THE CLOSURE OF MY ENHANCED DISABILITY MANAGEMENT PROGRAM FILE AT_____HEALTH AUTHORITY.

Print Name	Signature
( )	
Telephone Number	Date

[5] In the case of stay at work or graduated return to work planning and implementation, the manager/designate would generally receive information regarding your anticipated return to work date, your limitations and restrictions and the duration of the graduated return to work. In the case of an accommodation, the designated HR/LR personnel would receive the same information, plus the nature of your illness or injury and whether you require a temporary or permanent accommodation.