



Authorization Form for the Enhanced Disability Management Program

Purpose of the Authorization

Lifemark Health, a third-party provider of professional disability management services, provides disability case management services to _____(Employer) through the Enhanced Disability Management Program (“EDMP”) to offer support to employees during their absence from work or accommodation and provide guidance through the return to work process.

The purpose of this authorization is to allow Lifemark Health to collect, use and disclose information about me that is necessary for the operation of the 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 ¹may 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 Lifemark Health 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.).

¹ “disability benefits” are benefits provided by Work Safe BC, and Great West Life



Authorization to Access Information

Authorization to My Health Care Providers:

I authorize my health care provider(s)² to disclose to the Lifemark Health Disability Management Professional (“DMP”) my personal information³, including my medical information⁴ that is necessary for the delivery of disability management services to me in relation to this injury or illness.

Authorization to the Lifemark Health DMP:

I authorize the Lifemark Health DMP 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) HBT and their agent GWL. I further authorize HBT to share my personal information, including my medical information with the Lifemark Health DMP, as well as to my health care provider, and/or any service provider contracted by HBT for provision of disability management services to me with respect to this illness or injury,

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

Authorization to the Trustees of 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 the Lifemark Health DMP my personal information, including my medical 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 Lifemark Health.

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.



Return To Work and/or Accommodation - Authorization to the DMP:

I further authorize the Lifemark Health DMP to disclose necessary non-diagnostic information⁵ 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 WITH LIFEMARK HEALTH.

Print Name: _____

Signature: _____

Telephone: () _____

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.