UNIVERSITY OF CALGARY

Health Information Consent Form

Send completed form to confidential fax # 403-282-8603

Staff Wellness

PERSONAL AND CONTACT INFORMATION		
Name:	ID#:	Date of birth:
Home phone or cell #: ( )	E-mail address:	
Mailing address:		
Family physician name:		

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize my physician(s) and health care provider(s) to disclose medical information related to my current sick absence to University of Calgary's Staff Wellness and for Staff Wellness to share medical information with my health care providers. I understand that such information is necessary to assess and manage my claim and refusal to provide consent may impact sick leave benefits and/or a request for an accommodation.

I understand that any request for medical information will be sent to my physician(s) and/or treatment providers in writing and that I will be provided with a copy of the request.

The purpose of sharing my personal health information is for:

- Benefit administration, including eligibility for sick leave benefits
- Assessment and management of my condition and rehabilitation
- Return to work planning
- Providing an accommodation

I understand that the information will be collected, used, and disclosed in accordance with applicable laws, including the *Freedom of Information and Protection of Privacy Act* and the University of Calgary's Privacy Policy. Any questions regarding the gathering or use of this information can be directed to Staff Wellness at (403) 220-2918.

I understand that information will be provided to HR and my department on an as needed basis regarding:

- Timing of expected return to work
- Restrictions and limitations
- Work modifications needed to facilitate return to work or accommodation

This consent will be valid for the duration of my claim, or until revoked by me in writing.

A photocopy or facsimile of this authorization is as valid as the original.

Employee signature:	Date: