Authorization Form for the Enhanced Disability Management Program (NBA/ HSPBA)

This Authorization Form is to be used when the disability management service provider is the Healthcare Benefit Trust (HBT).

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 I may be entitled to.

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

Authorization to My Health Care Providers:

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

Authorization to the DMP:

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. I further authorize HBT to share my personal information, including my medical information with the DMP at _____ Health Authority, 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 _____ Health Authority 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 _____ Health Authority.

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

I further authorize the DMP of _____ Health Authority to disclose necessary non-diagnostic information 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.

In the event that further information is required to facilitate my safe return to work or I require an accommodation it will be discussed with me prior to the information being requested or disclosed.

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: _____ Date: _____