TO BE RETURNED TO DMI

Authorization for Release of Information

I authorize the release and/or exchange of health and/or medical information relevant to my present medical condition(s) and absence from work to the Disability Management Institute (DMI). I understand that the use and exchange of such information is strictly controlled and as such authorize my physician, health practitioner, and plan carrier to discuss and/or exchange health and/or medical information relevant to my present medical condition(s) and absence from work with the Disability Management Institute.

I understand DMI will create and maintain a case file relevant to my medical condition and absence from work. I also understand that DMI shall maintain such a file in strict confidence and in accordance with requirements of the Personal Information Protection and Electronic Documents Act (PIPEDA). I also understand that access to personal information concerning me will be limited to the employees of DMI who are involved in the handling of my claim.

I further understand that, except when DMI can, and does, lawfully restrict my access to personal information concerning me, I will be permitted to review copies of documents containing said personal information upon paying reasonable copying charges. I further understand that I will be permitted to request access to such documentation and have any errors in the personal information noted and corrected by formulating a written request to DMI.

____
Worker's Signature

____
Name of Worker (Please print)

____
Date

____
Signature of Witness

____
Name of Witness (Please print)

____
Date

Please fax a signed copy of this authorization to the Disability Management Institute at
604-552-3648 or
Toll free fax 1-866-963-9994

#203 -2071 Kingsway, Port Coquitlam, BC V3C 6N2 Phone: 604-552-3647 Fax: 604-552-3648