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RELEASE OF INFORMATION

SHORT-TERM DISABILITY MANAGEMENT PROGRAM

INSTRUCTIONS:

1. Complete this form by either filling it out electronically and providing a digital signature as outlined below, or by printing and signing a hard copy.
2. Send the completed form, which can be scanned or photographed, to your ASEBP STDM specialist by email at ShortTermDisability@asebp.ca, by fax to 780-438-5304, or mail the address above.
3. If you're unable to submit this form through any of these means, please call your ASEBP STDM Specialist.

Name (please print)	ASEBP ID	Date of birth (YYYY/MM/DD)

Street address	Home phone number / Mobile phone number (+ area code)

City/town	Province	Postal code

I authorize any **physician, health care provider, hospital, other health care facility or provider to disclose to the Alberta School Employee Benefit Plan** (ASEBP) any diagnostic, treatment and care or vocational information relative to my Short-Term Disability Management (STDM) Program case.

I authorize **ASEBP to release** all necessary information pertaining to my STDM case to independent consultants for the purpose of obtaining opinions on the extent of my medical condition and recommendations regarding course of treatment, my abilities and my capacity to return to work. I also authorize **ASEBP to release** any medical reports and information it receives to my health care provider(s), if required to assist in the management and treatment of my health condition.

I hereby authorize **my employer to disclose to ASEBP** all medical information they have relative to my current STDM case for the purpose of managing my STDM case including:

- any sick/medical notes, medical reports and independent medical evaluations including diagnostic, treatment and care or vocational information; and
- all information related to my Workers' Compensation Board claim, including decision letters and medical information.

I understand that **ASEBP** will only disclose the following information to my employer:

- decisions regarding my application, ongoing eligibility and participation in STDM program
- updates regarding the status of my STDM case (status reports do not include medical information)
- any information directly related to my ability to return to work with my employer, including any limitations I may have that require accommodations by my employer

I understand that my personal information will be kept confidential and secure. I consent to the collection, use, and disclosure of my personal information as described above or to government and regulatory authorities where required by law within provisions of the relevant privacy legislation. I understand that I may revoke my consent at any time and acknowledge that should I do so, access to STDM may not be available to me. I understand the reasons why the information requested is required and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure. I agree this authorization shall be in effect from the date below and shall be valid for the duration of my STDM case. A photocopy of this form shall have the same force and effect as the original.

Signature: _____ **Date:** _____

Consent is being obtained in accordance with sections 7, 8, 9 and 61 of the Personal Information Protection Act of Alberta and, in relation to personal health information, section 34 of the Health Information Act of Alberta. Be advised that in order to optimize the services we provide we may use service providers outside Canada to carry out certain functions on our behalf. In such situations, we enter into contracts and/or verify that appropriate privacy and security protocols are in place. If you have any questions regarding the collection, use and disclosure of your personal information, please refer to ASEBP's Privacy Policy at www.asebp.ca/privacy, or contact the privacy officer at 780-438-5300.