Ministry of Social Development and Social Innovation

CONSENT TO RELEASE SECTION 2, PHYSICIAN REPORT PERSONS WITH DISABILITIES REVIEW

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Employment and Assistance Act* and the *Employment and Assistance for Persons with Disabilities Act*. The collection, use and disclosure of personal information is subject to the provisions of the *Freedom of Information and Protection of Privacy Act*. Any questions about this information should be directed to your local Employment and Assistance Office.

LAST NAME	FIRST NAME	MIDDLE NAME

ADDRESS

CASE #	EAC CODE

I, ____, hereby consent to disclosure of **Section 2, Physician Report,** Report, contained in my Persons With Disabilities Designation Review by the Ministry of Social Development and Social Innovation, Health Assistance Branch to an employee of the Ministry responsible for determining my qualification as a person who has persistent multiple barriers to employment.

In consenting to this disclosure, I understand that my medical information will be used for the sole purpose of assessing my eligibility in relation to the medical condition requirement of the Employment and Assistance Regulation, section 2 (3) (b) (i) (A) or (B) or section 2 (4) (a) (i) or (ii).

SAMPLE

SIGNATURE OF CLIENT		DATE (YYYY MM DD)
WITNESS SIGNATURE	PRINT NAME	TELEPHONE