

PERMISSION TO DISCLOSE INFORMATION FORM (OPTIONAL)

EMPLOYEE INFORMATION (PLEASE PRINT)	
First and Last Name:	
Department / Job Title:	
UWaterloo Email (WatIAM):	@uwaterloo.ca
Personal Email address:	

STEP 1: READ THE AGREEMENT

Your privacy and confidentiality are important to Employee Health and Accommodations (EHA). We do not share information about your disability diagnosis or medical information with anyone internal or external to the University of Waterloo without expressed written consent from you.

Note: There are certain situations where your personal health information may be disclosed without consent. More information is available on EHA's Confidentiality and Disclosure of Information web page.

Complete the form below if you are requesting for EHA to share confidential information with, or receive confidential information from, a specified individual or organization. Examples may include a supportive person (i.e. spouse or friend), a family physician, or other health care practitioner, or campus partners for the purposes of coordinating services. This disclosure may occur in communications that happen via meetings (remote/in-person), emails, or phone calls.

STEP 2: INDICATE YOUR CONSENT

I consent to Employee Health and Accommodations (EHA) office sharing confidential information with, or requesting confidential information from (written or verbal) the following individual(s) or organization(s):

- ☐ First and Last Name:
Role / Relationship to above-named UW Employee:
Email Address:
Phone Number:

The information disclosed may include:

- ☐ Verifying my registration status with EHA
☐ Information about services I receive through EHA (including my eligible accommodations, supports and services)
☐ Obtaining my clinical and/or medical records
☐ Clarification of medical/clinical information and associated functional limitations
☐ Other, please specify:

The information is being disclosed for the purpose of:

- ☐ Designing, implementing, and facilitating an accommodation plan, sick leave, or other EHA service
☐ Coordinating services with campus partners
☐ Other, please specify:

Note: This consent will remain in place for your entire career at the University of Waterloo. You can withdraw your consent at any time by contacting Employee Health and Accommodations.

STEP 3: SIGN AND DATE

By signing below, I confirm I have read and understood the information, had the opportunity to ask questions, and provide my consent willingly. **Note:** This consent will cover your entire career at the University of Waterloo. Consent can be withdrawn at any time by contacting Employee Health and Accommodations.

Employee Signature:	Date (DD/MM/YYYY):
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