Ministry of Labour Relations and Workplace Safety
Office of the Workers' Advocate
300-1870 Albert Street
Regina, Canada S4P 4W1
Phone: 877-787-2456

Authorization to Release Medical Information

I, _____, authorize you to release my medical information that you have at your disposal to the following organization:

Office of the Workers' Advocate
300-1870 Albert Street
REGINA SK S4P 4W1

I understand that the medical information you release to the Office of the Workers' Advocate may include: written medical opinion(s); diagnostics/diagnostic reports; medical examination notes/reports; physical therapy reports; multi-disciplinary reports; clinic notes; etc.

I understand that the Office of the Workers' Advocate is collecting and utilizing this information for the purpose of determining if there is merit to proceed with an appeal and/or as evidence included in an appeal on my behalf as it relates to issue(s) in relation to my Workers' Compensation Board injury claim(s).

I understand that the information is collected, stored and utilized in accordance with *The Freedom of Information and Protection of Privacy Act* and *The Health Information Protection Act.*

_____
Date

_____ _____
Please type or print name Signature

PLEASE MAKE ANY COMMENTS ON SEPARATE SHEET