

**Canadian Thalidomide Survivors Support Program
Consent for Release of Medical Information**

To: _____
(doctor, hospital or health care professional)

Address: _____

City: _____ Province: _____

Postal Code: _____ Telephone: _____

Fax: _____

I, _____, HEREBY AUTHORIZE AND DIRECT you to provide to the Administrator of the Canadian Thalidomide Survivors Support Program:

a complete copy of my medical file including clinical notes, records, opinions, test results, x-rays reports and any and all documents with respect to the physical condition and treatment of Thalidomide (“condition”) and any other illness, without limitation whatsoever for the prior eighteen (18) months since my last healthcare visit. I also authorize for you and request that you be responsive to discussing, disclosing information, and providing opinions about my health by telephone calls or in writing to the Administrator and/or its agents for the purposes of assessing my disability level under the Canadian Thalidomide Survivors Support Program.

DOB (mm/dd/yyyy): _____

Provincial Health (Insurance) Card Number: _____

I understand that this information:

- will be used only to assess my disability level in order to determine what my ongoing yearly payment will be under the Canadian Thalidomide Survivors Support Program;
- is confidential and, except as required by law, will be used and disclosed only for the purpose of administering the Canadian Thalidomide Survivors Support Program.

Patient Name (please print)

Witness Name (please print)

Patient Signature

Witness Signature

Date (mm/dd/yyyy)

Date (mm/dd/yyyy)

Return by mail to:

**Canadian Thalidomide Survivors Support Program
3-505 133 Weber St N
Waterloo ON N2J 3G9
Email: info@tsspcanada.ca; FAX: 1-888-842-1332**