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
PO Box 507 STN B
Ottawa, ON, K1P 5P6
Email: info@tsspcanada.ca; Fax: 1-866-262-0816