UACL
Unifor Atlantic Communications Locals

PERMISSION TO DISCUSS MEDICAL INFORMATION

Employee Name	Employee Street Address	
City/Town	Province	Postal Code
Home Phone Number	Work Phone Number	

I give permission to Bell Aliant Health & Wellness and/or _____
to discuss the following medical information pertaining to:
(Check all that apply)

- o Scheduling/Appointment Information
- o Medical information, including my symptoms, diagnosis, medications and treatment plan
- o Other (describe): _____

Bell Aliant Health & Wellness and/or _____has my permission to discuss the above information with:

1. Name: _____ Address: _____

Title: _____ City/Town: _____

Work Phone: _____ Province: _____

Alternate Phone: _____ Postal Code: _____

2. Name: _____ Address: _____

Title: _____ City/Town: _____

Work Phone: _____ Province: _____

Alternate Phone: _____ Postal Code: _____

I understand that I have the right to revoke my permission in writing at any time.

Signature of Employee: _____ Date: _____

Signature of Witness: _____ Date: _____

Fax completed form to Bell Aliant Health & Wellness: 1-866-336-3028