



# CEP Atlantic Communications Council

Bargaining Agent for CEP Locals 401, 410, 506 & 2289

## 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 Aliant Health and Wellness and/or \_\_\_\_\_ to discuss the following medical information pertaining to \_\_\_\_\_.  
(Check all boxes that apply)

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

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 \_\_\_\_\_