Ontario

Ministry of Community and Social Services

Consent to Release Medical Information
Ontario Works

Name	Date of Birth *(dd,mm,yyyy)*	Case Org.
Address	Member ID	
	Health Number	
Postal Code -		

1. I, ______________________________ *am an applicant for Ontario Works.

2. I hereby authorize you ______________________________
(Name of attending physician)

   i) to complete the attached medical report; and
   ii) to provide to authorized representatives

   of the ______________________________
   (Ontario Works delivery agent)

   and the Ministry of Community and Social Services all additional relevant medical information contained in records pertaining to me.

3. So long as I am an applicant or recipient of financial assistance, I further authorize you to provide the above-noted authorized representatives at any time any additional medical information requested.

4. In the event that I apply for an appeal to the Social Benefits Tribunal, I acknowledge that the above-noted authorized representatives may release to the Social Benefits Tribunal any or all of the information provided by you pursuant to this consent.

5. Should I become eligible for financial assistance under the *Ontario Works Act, 1997,* I agree that the consent set out shall apply.

6. I fully understand the nature and purpose of this consent and give my consent and authorization voluntarily.

Dated at ____________ the ____________ day of ____________ 20 ______ .

______________________________ Witness

______________________________ Signature of Applicant

* In situations where the applicant or recipient is unable to provide consent in writing, by reason of physical or mental disability, the consent of the legal guardian or, if there is no legal guardian, the next of kin, will suffice.

Important Message to Attending Physician

The information is to be used in connection with your patient's application for assistance under the *Ontario Works Act, 1997,* (administered by the Ontario Works delivery agents).

Medical information pertaining to your patient may therefore be exchanged between Ontario Works delivery agents.

Please complete and sign the attached report and forward it to our attention, along with copies of any additional information which you may feel may be helpful.

For further information, please contact: Ontario Works Staff ______________________________

Ontario Works Office ______________________________ Telephone ______________________________

This Part to be Retained by Attending Physician

Ontario

Ministry of Community
and Social Services

Limitations to Participation

Name	Date of Birth *(dd,mm,yyyy)*	Case Org.
Address	Member ID	
	Health Number	
Postal Code -		

The Intent of Ontario Works is to enable clients to take the shortest route to employment. The above mentioned patient has identified that they are unable to fully participate in Ontario Works due to medical limitations. This form is intended to obtain detailed medical information in order to help us assess the patient's participation in Ontario Works and to determine a participation plan.

Type of Health Care Practitioner: ☐ General Practitioner ☐ Specialist ☐ Counsellor

1. Is this person a regular patient of yours? ☐ Yes ☐ No

   If yes, how frequently have you seen this patient in the past 2 years?

   Other Doctors that have supplied medical information:

   1. ______________________ (doctor) ______________ (date)
   2. ______________________ (doctor) ______________ (date)
   3. ______________________ (doctor) ______________ (date)

2. Are there any medical limitations to participating in activities of daily living (see below)?

   ☐ **Yes** (if yes, please complete form) ☐ **No** (if no, please sign the certificate on the reverse)

☐ heavy lifting	☐ sitting	☐ energy / stamina
☐ light lifting	☐ bending	☐ standing
☐ walking	☐ ability to concentrate	☐ fine motor skills
☐ operating machinery	☐ drive	☐ other (specify)

   Please describe: ______________________

3. Description of medical limitations / impairment

4. Prognosis: ☐ Good ☐ Fair ☐ Poor ☐ Guarded

5. Are there any devices that will enable the patient to function with less restrictions?

6. Are there any current limitations as a result of:

   ☐ Medication ☐ Therapy ☐ Tests ☐ Referral to Specialists ☐ Other ______________

   When will current treatment be reassessed? ______________

   Do you anticipate a proposed change to current therapy / treatment? ☐ No ☐ Yes, please specify:

   Do you expect any barriers to the above? ______________

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Certificate of Attending Physician

(Please print)

I, ______________________________ am a legally qualified

medical practitioner and this report contains my findings and considered opinion at this time.

Signature ______________________________ Date ______________________

Address ____

____

It may be necessary to release to the applicant the contents of this form.

Notice with Respect to the Collection of Personal Information
(Freedom of Information and Protection of Privacy Act)
(Municipal Freedom of Information and Protection of Privacy Act)

This information is collected under the legal authority of the *Ontario Disability Support Program Act*, 1997, sections 5, 10, 45 & 46 or the *Ontario Works Act*, 1997, sections 7, 8, 15, 57 & 58 for the purpose of administering Government of Ontario social assistance programs.
For more information contact

______________________________ at ( ) ______________________ ,

in your local Ontario Works or ODSP office.

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