



AUTHORIZATION TO DISCLOSE INFORMATION / CONSENT FOR VOCATIONAL REHABILITATION

First Name	Initial	Last Name	Social Insurance Number
Home Address (No., Street, Apt., or R.R.)			City
Province or Territory	Country other than Canada	Postal Code	Telephone Number

- **I hereby authorize** any physician, nurse practitioner, hospital, employer, educational institution, medical or vocational agency as well as federal/provincial/municipal employment programs, Workers' Compensation Board, private insurance plans to disclose information contained in their records to Canada Pension Plan(CPP), for the purpose of determining whether I can benefit from Vocational Rehabilitation under the terms of the Canada Pension Plan.
- **For the purpose** of providing further evaluation of my rehabilitation potential, I agree, upon request by the Canada Pension Plan Administration, to be assessed by a qualified physician and a vocational rehabilitation consultant and to participate in such vocational tests or programs as recommended. I also authorize the Canada Pension Plan Administration to provide any relevant medical and/or vocational information relating to my disability to the evaluating physician, rehabilitation consultant or private insurer for Canada Pension Plan vocational rehabilitation purposes.
- **Any personal information** received by the Canada Pension Plan is protected under the Canada Pension Plan and the Privacy Act. I have the right to request access to this personal information and am aware that the information may be used or disclosed within the conditions imposed by the Canada Pension Plan and the Privacy Act and outlined in the Personal Information Bank ESDC PPU 146.
- **I have read** the above statements. I understand that this information is essential to determine rehabilitation potential and to establish an individualized rehabilitation program. In addition, this information will be used to determine my continuing eligibility to disability benefits under the terms of the Canada Pension Plan.

TO BE COMPLETED BY THE BENEFICIARY/CLIENT			
Signature of Beneficiary/Client	Year	Month	Day

TO BE COMPLETED BY A WITNESS IF BENEFICIARY/CLIENT SIGNED WITH A MARK "X"			
Signature of Witness	Year	Month	Day
Home Address (No., Street, Apt., or R.R.)			
City	Province or Territory	Country other than Canada	Postal Code
This Authorization/Consent form shall be valid for two years from the date of signature unless previously revoked in writing by the beneficiary/client signing this form. Any photographic or facsimile copy shall be as valid as the original.			

Service Canada delivers Employment and Social Development Canada
programs and services for the Government of Canada