Interior Health

AUTHORIZATION TO RELEASE INFORMATION FORM

I. DISCLAIMER

I HEREBY authorize and direct Interior Health to disclose my personal information to the HCAP funded post-secondary institution (PSI) for purpose of gaining admission and supporting my student success for an Interior Health sponsored education program.

THIS authorization is valid for a period of 90 days following graduation unless consent is withdrawn in writing prior to that date.

Personal information contained on this form is collected under the Freedom of Information and Protection of Privacy Act (FIPPA) and will only be used for the purpose of this request. I understand that my information shall remain confidential and secure as required under FIPPA.

II. PERSONAL CONTACT INFORMATION BEING DISCLOSED

I approve the following information can be shared between the IH HCAP team and the applicable post-secondary institute:

- Employee name and primary worksite
- HCAP funding confirmation
- PSI admission status
- Academic information and disciplinary status
- Attendance, approved leaves and program withdrawals
- Graduation status and HCA Registry confirmation

III. SIGNATURE AND CONSENT

Name (please print): _____

Signature:_____

Date: _____

I understand that I may withdraw my authorization at any time with written notice to

Health Career Access Program