AUTHORIZATION TO
COLLECT, USE & DISCLOSE PERSONAL INFORMATION

Employee Name: _____

Employee #: _____

I understand that:

- Personal information and personal health information will be collected from me for the purpose of administering payroll and benefits for Southern Health-Santé Sud, which will include the submission of forms containing personal information to the Canada Revenue Agency, Civil Service, HEPP/HEBP in relation to Group Healthcare, Group Life, Dental, Disability and Rehabilitation and Retiree Group Healthcare plans. This includes supporting documentation regarding eligibility and entitlement to benefits. (hereinafter, the "Identified Purpose")

- For the Identified Purpose, it may be necessary to *collect* my personal information and personal health information for the purpose of *disclosure* to individuals and organizations acting on behalf of Southern Health-Santé Sud such as:
    - Employees of Southern Health-Santé Sud; actuaries; accreditation surveyor; lawyers; physicians; healthcare providers; other insurers; and government regulators.

- The privacy of individuals about whom the information relates and the confidentiality of personal information collected will be protected in accordance with relevant privacy policies and privacy law(s).

- I may withdraw all or part of my consent at any time, in writing, but that doing so may interfere with fulfilling the Identified Purpose.

I, _____ (please print name) authorize Southern Health-Santé Sud, and the individuals and organizations authorized to act on their behalf, to collect, use and disclose my personal information and my personal health information for the Identified Purpose. A reproduction of this authorization is as valid as the original.

Employee Signature: _____

Date Signed: _____ (Day/Month/Year)