

Worker Appeals Advisor Branch

Personal information you provide to the Alberta Fair Practices Office (FPO) is collected under the authority of section 33(c) of the *Freedom of Information and Protection of Privacy Act* (FOIP) and is managed in accordance with Part 2 of FOIP. The personal information you provide will be used by the FPO for the purpose of providing appeals advisory services for your Workers' Compensation Board (WCB) claim. Should you wish to have your personal information corrected or have any questions or concerns pertaining to the collection of information, please contact General Counsel, Suite 1000, 10th Fl, 10123 – 99th St NW, Edmonton, AB T5J 3H1, 1-866-427-0115.

PLEASE PRINT CLEARLY OR TYPE.

A. Claimant Information:

Surname		First Name		Initial
Date of Birth (dd/mm/yy)		Phone	Email	
Mailing Address				
City		Province	Postal Code	
Legal Business Name of Employer (at the date of injury)				
Communication Preference: <input type="radio"/> Email <input type="radio"/> Mail <input type="radio"/> Telephone				

B. Authorization of Formal Representative

Important Note: If any of the below information is not provided or is incomplete, it will cause a delay in proceeding with your file.

I authorize the FPO Worker Appeals Advisor Branch (WAAB) to represent me with respect to:

PLEASE SELECT **ONLY ONE** OF THE FOLLOWING OPTIONS:

- CURRENT CLAIM ONLY
- OR**
- ALL CLAIMS: PAST, PRESENT, AND FUTURE

CLAIM NUMBER(S)	DECISION DATE (dd/mm/yy)	DECISION SUMMARY

Worker Appeals Advisor Branch

C. Authorization to Collect Information from the WCB:

I authorize the FPO WAAB to collect information, including personal information, about my claim verbally, electronically, in writing and/or in person from the WCB for the purposes of reviewing and/or appealing a WCB decision and providing advocacy services. The WCB is authorized to disclose personal information to the FPO WAAB that is necessary for the purpose of providing appeals and advocacy services. This includes, but is not limited to, a copy of my claim file and copies of correspondence sent to me by the WCB.

D. Authorization to Share Medical Records:

I authorize the FPO WAAB to share and discuss my medical records with my treating physician(s) to seek clarification or get an opinion on any medical matter relating to my claim. If FPO WAAB requires medical information from my previous WCB claim files to determine past injuries and how they impact my current claim, I authorize FPO WAAB to obtain this information from the WCB.

E. Expiry of Authorization:

This authorization will expire when one of the following occurs:

- the appeal matter has been concluded
- the services of the WAAB are no longer required; or
- you rescind the authorization.

Should you wish to revise or rescind your authorization, you are responsible for submitting a written notification to the WAAB.

Should you require further assistance from the FPO WAAB following the expiry of this authorization, you will be required to submit a new authorization form.

F. Definition of a Formal and Informal Representatives:

A Formal Representative may access information about your claim directly from the WCB. They have the authority to make representations on your behalf, can request a copy of your claim file and will receive a copy of correspondence sent to you.

An informal representative may assist you by providing and receiving information about your claim with WCB employees. They do not have the authority to make decisions on your behalf, cannot request a copy of your claim and will not receive a copy of correspondence sent to you. If you would like to appoint an informal representative, you must submit an Informal Representative Consent Form.

G. Authorization:

I authorize the FPO WAAB to act on my behalf for the purposes of assisting with my claim(s), which include reviewing and/or appealing a WCB decision. The FPO WAAB may make representations on my behalf and proceed with a documentary or in person hearing in my absence if the FPO WAAB considers this action to be appropriate in the circumstances.

Worker's Signature

Date

Edmonton office:

Suite 1000, 10th Fl, 10123 99th St NW, Edmonton, AB T5J 2H1



Toll-free 1-866-427-0115



info@fpo.alberta.ca



780-638-2328



fpoalberta.ca

Calgary Office:

602, 1701 Centre Street NW, Calgary, AB T2E 7Y2

V5-08.18.2019

Consent to Release Medical Information

PLEASE PRINT CLEARLY OR TYPE.

Worker's Name:	
Date of Birth (dd/mm/yy)	

I, _____, authorize you to release copies of all information and medical reports, including psychological and psychiatric reports, and work history reports to the Alberta Fair Practices Office for the purpose of reviewing my workers' compensation claim and/or pursuing any related appeal. I also authorize you to communicate with the Fair Practices Office if additional information or clarification is required.

Important Note: If any of the above information is not provided or is incomplete, it will cause a delay in proceeding with your file.

Worker's Signature

Date

The Fair Practices Office may use and disclose the information as required or authorized by law and pursuant to the *Freedom of Information and Protection of Privacy Act*.