Medical Information Form

Lease ID: <<Lease ID>>

Consent to release information

Patient's name: (*print*) ____

I hereby authorize the release of personal health information to Manitoba Housing for the purpose of determining eligibility or suitability for housing.

I understand that this information may be kept on file for the length of tenancy and I may cancel or amend this consent at any time in writing to Manitoba Housing.

Signature: ________________________________ Date: ________________

Manitoba Housing is collecting personal information and personal health information about housing applicants and qualified household members (if any), under the authority of Manitoba Housing programs for the purposes of establishing their eligibility for rental housing. The information provided will be protected by the privacy provisions of The Freedom of Information and Protection of Privacy Act and The Personal Health Information Act.

To be completed by a Medical Professional

In order to assist Manitoba Housing in determining eligibility and establishing appropriate housing, please answer the following questions to the best of your ability.

CERTIFIED MEDICAL PROFESSIONAL SECTION
The following professions are qualified to complete this form. Please check one:

- ☐ Medical doctor
- ☐ Nurse Practitioner
- ☐ Optometrist/Ophthalmologist
- ☐ Audiologist
- ☐ Psychologist
- ☐ Occupational Therapist
- ☐ Physiotherapist
- ☐ Social Worker

Does the patient have a disability that prevents them from working and taking part in training for 12 months or more? ☐ Yes ☐ No

Does the patient need to move out of their current home for medical reasons? ☐ Yes ☐ No
If yes, please explain (e.g. proximity to support services, mobility issues, and mental health limitations).

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Does the patient require any physical enhancements to their housing for medical reasons?
☐ Yes ☐ No
If yes, please describe the enhancements required (e.g. accessibility, elevator, extra space for medical equipment)

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Does the patient require any support services to live independently? ☐ Yes ☐ No
If yes, please describe the services:

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Is there a requirement for a caregiver to reside with the tenant? ☐ Yes ☐ No
If yes, what is the duration that the live-in caregiver will be required?

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I declare that all statements made in this document are true, and to the best of my professional knowledge.

Name: (print) ____

Address: ________________________________ Phone: ____________________

Signature: ______________________________ Date: _____________________