NOTE – DO NOT USE THIS FORM FOR ALCOHOL-RELATED OFFENCES

Referring Port of Entry: _____

Dr. Ian Zatzman, M.D.
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AUTHORIZATION TO USE & DISCLOSE MEDICAL/PSYCHIATRIC INFORMATION

Please read carefully and seek legal advice as required before you sign the consent:

To gain admission to the United States of America, the Government of the United States requires detailed information from your health care provider(s). Our fee for processing this form and providing information to representatives of the Government of the United States of America is $500.00 CAD. In the event that Dr. Ian Zatzman is unable to process this form due to additional information being required, Dr. Ian Zatzman may charge you a fee of $500.00 CAD per hour for communications with you, your health care provider(s) and/or legal adviser, as well as for reviewing and disclosing any additional information to representatives of the Government of the United States of America. Payment for communications and processing of any additional information must be received in full prior to the release of any information to representatives of the Government of the United States of America. You will be notified if additional information is required. Please return completed forms and payment of $500.00 CAD via certified cheque or money order to: Dr. Ian Zatzman, 955 Major Mackenzie Drive West Ste 208, Vaughan, ON L6A 4P9. Please do not call our office; you will be notified when your file has been processed.

Name (printed): _____

Address: _____ City: _____ Province: _____

Postal Code: _____ Ten-Digit Telephone Number: _____

Passport:

_____

On the line above specify: Country of origin of passport, number, place of issue, and expiration date

Please provide brief, but concise, detailed information on a separate page in answer to these questions.

1) Where and why were you denied admission to the United States of America?
2) Are you suffering from or being treated for any medical or psychiatric disease or disorder (include details of treating doctors, current treatment, and a list of medications including dose)?
3) If you have a history of medical or psychiatric problems, do you have insurance to supplement your provincial government plan in the event that you require medical attention while in the United States? Does the policy exclude pre-existing conditions?
4) Do you have a history of harmful or violent behavior to self, others or property? This includes suicide attempts, assault, battery, charged or convicted of care or control of a motor vehicle while impaired or any alcohol or drug related driving offense.
5) Do you have a history of substance use/abuse whether the substance was legally prescribed or illegally procured? If so, list the substances(s) including marijuana and alcohol and the date of the last use of the substance(s).
6) If you have ever been arrested, please provide a complete summary of dates, charges and resolution for each.

CONSENT: I understand that there is no physician-patient relationship between Dr. Ian Zatzman and myself. I authorize my treating health care provider(s) including hospitals to release and disclose information about me including medical, psychiatric/psychological information to Dr. Ian Zatzman. I understand that the information submitted to Dr. Ian Zatzman will be used to provide representatives of the Government of the United States of America documentation regarding my medical/mental health status and that I will not be provided with a copy of any reports or documents sent to the Government of the United States of America. I understand that completion of this process with Dr. Ian Zatzman does not guarantee my admission into the United States of America. I understand that the determination regarding my admissibility into the United States of America will be made by representatives of the Government of the United States of America and not Dr. Ian Zatzman. I authorize the re-disclosure and release of information including medical, psychiatric/psychological information, in whole or in part, by the recipient to representatives of the Government of the United States of America with the understanding that I will not be provided with a copy of any information that has been released, nor will I be provided a copy of my file, and that neither Dr. Ian Zatzman or my health care provider(s) have any control over how information released to representatives of the Government of the United States of America may be utilized. I further understand that should I wish to obtain a copy of any information that has been released to representatives of the Government of the United States of America, that it must be requested from the Government of the United States of America and not from Dr. Ian Zatzman. In signing this consent, I specifically authorize and consent to the exchange and sharing of information between representatives of the Government of the United States of America and Dr. Ian Zatzman. I understand that I am reliance thereon. I hereby declare that the answers I provide to the above questions are true and correct to the best of my knowledge. I authorize the release of the above information to representatives of the Government of the United States of America and I further consent to the disclosure and exchange of information between the authorized parties as outlined above. I agree that the relationship and the resolution of any and all disputes arising there from between myself and Dr. Ian Zatzman shall be governed by and construed in accordance with the laws of the Province of Ontario and the laws of Canada applicable therein. I hereby agree that if I commence any legal or other proceedings with respect to any aspect of the provision, use or disclosure of the information requested by this form or the reporting of Dr. Ian Zatzman to the Government of the United States of America and its representatives by Dr. Ian Zatzman, I will only do so in the Province of Ontario, and I hereby irrevocably submit to the exclusive jurisdiction of the Courts of the Province of Ontario, situated in the City of Toronto, Ontario

Signature: _____ Date: _____

TO BE COMPLETED BY YOUR TREATING PHYSICIAN/PSYCHIATRIST/CLINICAL PSYCHOLOGIST

Name of Applicant: _____ Date of Birth: _____

Dear Doctor: To determine your patient's medical status for entry into the United States of America, we require answers to the following questions. Any fee for your completion of the form is your patient's responsibility. Any "yes" answer requires a concise narrative containing detailed information transcribed on your letterhead. We will not accept hand printed/written reports. We cannot make a classification based on unreadable information. We require copies of admission/discharge summaries for all psychiatric and substance abuse admissions. Please be certain that your patient understands that any or all of the information you provide us will be released in whole or in part to representatives of the Government of the United States of America and that neither you nor we have any control over how that information will be utilized.

1. Patient is presently diagnosed, being treated for or taking medication for any medical or psychiatric disorder?
   □ No; □ Yes; □ Do not know – provide details including: The diagnoses, prognosis, the names and doses of ALL medication(s), current status (e.g. is the condition stable and if so, for how long? Has there been any change in your patient's condition or treatment in the last 3 months?)

2. Patient has a history of harmful or violent behavior to self, others or property now or at any time in the past?
   □ No; □ Yes; □ Do not know – provide details in a narrative form including nature and history of the harmful behavior, when it last occurred, if under control, how is control maintained, your opinion as to whether the harmful behavior is likely to recur. Your opinion will be relied upon to classify your patient for entrance to the United States.

3. Patient has a history of hospital admission for psychiatric disorder: □ No; □ Yes; □ Do not know – provide details including diagnoses, dates and a complete history of any harmful or violent behavior. Include copy of all admission/discharge summaries for all hospital admissions.

4. Patient has a history of alcohol, substance abuse or prescription drug abuse: □ No; □ Yes; □ Do not know. Substance abuse includes, but is not limited to the non-prescribed use of: Marijuana, cannabis, amphetamines, cocaine, opioids, sedatives, hypnotics and anxiolytics and to the use of prescribed drugs in quantities that would suggest abuse or dependence. Provide details including dates of treatment and any history of associated harmful or violent behavior or criminal behavior. Please provide admission and discharge reports from treatment facilities. List the substance(s) and date of last use of abused substance(s). The information you provide will be relied upon in order to classify your patient for entrance to the United States.

5. Patient has a history of communicable disease of public health significance: □ No; □ Yes; □ Do not know (e.g. tuberculosis, syphilis, other STDs, any current pandemic or epidemic infection) – if yes, please provide details of diagnosis and treatment.

6. Is it safe for your patient to fly on an airplane; ride a bus/train/automobile alone? □ No; □ Yes; □ Do not know. If no or do not know, please provide details in your report.

I have treated this patient for _____ years/months. I am a legally qualified physician or clinical psychologist licensed in the Province of _____. I understand that the information I am supplying may in whole or in part be provided to representatives of the Government of the United States of America. I hereby declare that the above information is true and correct to the best of my knowledge and based on the information available to me.

YOUR NAME IN FULL (printed): _____

YOUR ADDRESS: _____

YOUR TEN-DIGIT PHONE NO.: _____

YOUR EMAIL ADDRESS: _____

YOUR SIGNATURE: _____ M.D. DATE: _____