

The patient/client or his/her authorized representative must complete this form before the Information Custodian may disclose the patient's/client's health information to someone else (unless *Alberta's Health Information Act* authorizes disclosure without consent).

Patient/Client Information				
Last Name		First Name		
Mailing address				
City/Town		Province	Postal Code	
Date of Birth (yyyy-Mon-dd)		Personal Health Number		
Representative Information				
Last Name		First Name		
Organization (if applicable)				
Phone	Address	City/Town	Province	Postal Code
Purpose of Disclosure				
Authority of person(s) giving consent (if signing on behalf of the patient/client, indicate your authority below and provide a copy of the document which authorizes you).				
<input type="checkbox"/> Guardian (or Trustee)		<input type="checkbox"/> Nearest relative under Mental Health Act		<input type="checkbox"/> Agent
<input type="checkbox"/> Personal representative		<input type="checkbox"/> Power of Attorney		<input type="checkbox"/> Written authorization
<input type="checkbox"/> Specific decision maker				
Request Information				
Details of Request What health information do you want to be disclosed? (e.g. diagnostic tests/results, health charts, EMS reports, etc.) Please provide specific details about the health information.				

What is the time period of the health information requested? If known, please provide specific start and end dates				
Start Date (yyyy-Mon-dd)		End Date (yyyy-Mon-dd)		
I authorize the Information Custodian for these records to disclose the health information described above to the individual(s) or organizations(s) identified above. I understand why I have been asked to disclose my individually identifying information. I am aware of the risks and benefits of consenting, or refusing to consent, to the disclosure of my health information. I understand that I may revoke this				
Date consent is effective (yyyy-Mon-dd)		Expiry Date (valid for 2 years if no date provided) (yyyy-Mon-dd)		
Name of person giving consent		Signature	Date (yyyy-Mon-dd)	

Personal information on this form is collected under section 20 of the Health Information Act.

Definitions

Authority of person(s) giving consent *(if signing on behalf of the patient/client, indicate your authority below and provide a copy of the document which authorizes you).*

Guardian (or Trustee) - of a minor under the age of 18 years, who is not determined to be a mature minor named in a Guardianship Order/appointed under the Adult Guardianship and Trusteeship Act, if access to health information related to the powers and duties of the guardian (or trustee)

Nearest relative under Mental Health Act – if access to health information is necessary to carry out obligations of the nearest relative

Agent – appointed in an enacted personal directive according to the Personal Directives Act

Personal representative – of a deceased patient, if the access to information relates to administration of the individual's estate

Power of attorney – if access to health information related to the powers and duties of the attorney

Written authorization – any written authorization from the individual to act on the individual's behalf

Specific decision maker – as defined in the Adult Guardianship and Trusteeship Act