

The patient/client or his/her authorized representative must complete this form before Alberta Health Services 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		
<input type="checkbox"/> Mr <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss	Last Name	First Name
Mailing Address		
City/Town	Province	Postal Code
Date of Birth ( <i>yyyy-Mon-dd</i> )	Personal Health Number	
Representative Information		
Last Name	First Name	
Organization ( <i>if applicable</i> )		
Mailing Address		
City/Town	Province	Postal Code
<b>Representative is authorized to: (<i>check one</i>)</b>		
<input type="checkbox"/> Exercise all my rights under the <i>Health Information Act</i> <input type="checkbox"/> Exercise my rights to access all my records containing my health information <input type="checkbox"/> Exercise my right to access only the following records containing my health information ( <i>describe</i> ) _____ _____ <input type="checkbox"/> Other ( <i>describe in detail</i> ) _____ _____ _____ _____		
I confirm that my representative has the authority to carry out the above rights and responsibilities on my behalf.		
Name ( <i>Print Last Name, First Name</i> )	Signature	
Date ( <i>yyyy-Mon-dd</i> )	Expiry Date ( <i>optional</i> ) ( <i>yyyy-Mon-dd</i> )	

Witness Last Name	Witness First Name	Witness Signature
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*Personal information on this form is collected under section 20 of the Health Information Act. AHS is collecting the personal health number as a custodian under Section 21(1) of the Health Information Act. If you have questions about the collection and use of any information on this form contact the Disclosure Help Line at 1.855.312.2265.*