| Name *(last, first)* | | |
|---|---|---|
| Birthdate *(yyyy-Mon-dd)* | | |
| PHN# | HRN# | CoMIS# |

## Consent to Disclose Health Information

The patient/client or his/her authorized representative must complete this form before AHS may disclose the patient's/client's health information to someone else *(unless Alberta's Health Information Act authorizes disclosure without consent)*. The information on this form, together with any record authorizing a representative to act on behalf of the patient/client, is being collected under part 3 of the Health Information Act for the purpose of recording the patient's/client's consent to the specified disclosure and will be filed on the patient/client record. For questions about this collection of information, contact the program area that provided you this form or contact the Chief Privacy Officer at 10301 Southport Lane SW, Calgary, AB T2W 1S7 or call 1.877.476.9874.

| Patient/client name | | | |
|---|---|---|---|
| Date of birth *(yyyy-Mon-dd)* | | Personal health number *(authorized by HIA s.21(1))* | |
| Address | City/Town | Province | Postal Code |

Details of health information being disclosed *(write in full without abbreviations, include dates of treatment)*

**Identify below where records exist**

| Health service provider, hospital, clinic, program | City/Town |
|---|---|
| | |
| | |
| | |
| Date consent is effective *(yyyy-Mon-dd)* | Expiry date *(valid for 2 years if no date)* *(yyyy-Mon-dd)* |

Name of individual(s)/organization(s) information is being disclosed to

| Phone | Address | City/Town | Province | Postal Code |
|---|---|---|---|---|
| | | | | |

Purpose(s) 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)*

- ☐ **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 relates 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 relates 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

I authorize AHS to disclose the health information described above to the individual(s) or organization(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 consent in writing at any time.

| Name of person giving consent | Signature | Date *(yyyy-Mon-dd)* |
|---|---|---|
| | | |