CONSENT TO THE DISCLOSURE OF INDIVIDUALLY IDENTIFYING HEALTH INFORMATION [AUTHORIZED BY HIA s34]

The patient or their authorized representative must complete this form before the _____ custodian or health team representative will disclose the patient's health information to someone else (unless Alberta's Health Information Act authorizes disclosure without consent).

Patient Information
Patient Name:
Date of Birth:
What health information do you want disclosed?
Please provide details about the health information you want disclosed, such as the time period of the records.
What individual/organization is the patient's health information being disclosed to?
Name of Individual / Organization:
Address: Phone:
What is the purpose for disclosure?
Please provide the reason why you want to disclose the health information (required).
Authorized Representative (required when asking for health information on behalf of another person)
If you are signing on behalf of a patient, please choose one of the options below and provide a copy of supporting documents. I, _____, am ☐ **Guardian** - the parent or legally appointed guardian of the patient who is under 18 years of age and who is not a mature minor in relation to their health information. ☐ **Guardian / Trustee** - the guardian or trustee appointed for the adult patient under the Adult Guardianship and Trusteeship Act exercising my powers or duties as their guardian or trustee. ☐ **Agent** - the patient's agent named in an activated Personal Directive under the Personal Directives Act exercising my authority set out in the Personal Directive. ☐ **Personal representative** - the personal representative of a deceased patient appointed by the patient's will or by the Court, administering the patient's estate.

☐ **Power of attorney** - the patient's named attorney in a Power of Attorney currently in effect exercising my powers and duties conferred by the Power of Attorney.

☐ **Nearest relative** - the patient's nearest relative selected in accordance with the Mental Health Act carrying out my obligations as the nearest relative.

☐ **Specific decision-maker -** the patient's specific decision maker, supportive decision-maker, or co-decision maker, authorized in accordance with the Adult Guardianship and Trusteeship Act carrying out the related duties.

☐ **Written authorization -** a person with the patient/client's written authorization to act on the patient/client's behalf.

Consent for Disclosure

I authorize _____, custodian, or health team representative to disclose the patient's health information described above to the individual or organization(s) identified above. I understand why I have been asked to disclose my health information and I am aware of the risks and benefits of consenting or refusing to consent. I understand I may revoke this consent in writing at any time.

Date consent is effective (yyyy/mm/dd):

Expiry date (yyyy/mm/dd) (valid for two years if not date provided)

Name of person giving consent:

Phone:

Email:

Signature

Date signed (yyyy/mm/dd)

Information on this form and the supporting documentation are collected under the authorization of sections 20 - 22 of the Health Information Act for the purpose of responding to your request and will be filed on the patient record. If you have questions about the collection and use of any information on this form, please contact our privacy officer _____.