

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

<b>Section A: Patient/Client Information</b>				
Patient/Client Name				
Date of Birth (yyyy-Mon-dd)			Personal Health Number	
<b>Section B: What health information do you want disclosed?</b>				
Please provide details about the health information you want disclosed, such as the name of the AHS location/facility that provided the health service and the time period of the records.				
<b>Section C: What individual/organization is the patient's/client's health information being disclosed to?</b>				
Name of Individual/Organization			Email	
Address	City/Town	Phone	Province	Postal Code
<b>Section D: What is the purpose for disclosure?</b>				
Please provide the reason why you want to disclose the health information ( <i>required</i> ).				
<b>Section E: Authorized Representative (<i>required when asking for health information on behalf of another person</i>)</b>				
If you are signing on behalf of the patient/client named in section A, please choose one of the options below and provide a copy of supporting documents.				
<input type="checkbox"/> <b>parent or legally appointed guardian</b> of the patient/client who is under 18 years of age and who is not a mature minor in relation to their health information.				
<input type="checkbox"/> <b>guardian or trustee</b> appointed for the adult patient/client under the <i>Adult Guardianship and Trusteeship Act</i> exercising my powers or duties as their guardian or trustee.				
<input type="checkbox"/> patient/client's <b>agent</b> named in an activated Personal Directive under the <i>Personal Directives Act</i> exercising my authority set out in the Personal Directive.				
<input type="checkbox"/> <b>nearest relative</b> of a deceased patient/client as defined in the <i>Personal Directives Act</i> . <b>Also complete Section F.</b>				
<input type="checkbox"/> <b>personal representative</b> of a deceased patient/client appointed by the patient/client's will or by the Court, administering the patient/client's estate.				
<input type="checkbox"/> patient's <b>named attorney</b> in a Power of Attorney currently in effect exercising my powers and duties conferred by the Power of Attorney.				
<input type="checkbox"/> patient/client's <b>nearest relative</b> selected in accordance with the <i>Mental Health Act</i> carrying out my obligations as the nearest relative. <b>Also complete Section F.</b>				
<input type="checkbox"/> patient/client's <b>specific decision maker, supportive decision maker, or co-decision maker</b> , authorized in accordance with the <i>Adult Guardianship and Trusteeship Act</i> carrying out the related duties.				
<input type="checkbox"/> <b>person with written authorization</b> from the patient/client to act on their behalf.				
<b>Section F: What is your relationship to the patient/client?</b>				
I am the _____ ( <i>insert relationship</i> ) and confirm that to the best of my knowledge, I am the nearest relative ranked in the order of authority as indicated in the applicable legislation.				
<b>Section G: Consent for Disclosure</b>				
I authorize Alberta Health Services to disclose the patient/client'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-Mon-dd)			Expiry date (yyyy-Mon-dd)( <i>valid for 2 years if no date provided</i> )	
Name of person giving consent ( <i>Please print</i> )			Phone	
Signature			Date (yyyy-Mon-dd)	
Information on this form and the supporting documentation are collected under the authorization of sections 20 - 22 of the <i>Health Information Act</i> for the purpose of responding to your request and will be filed on the patient/client record. 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.				
<b>Office Use Only</b> - This form is not to be used to document a disclosure or release of information. Information released must be documented in accordance with section 41 of the <i>Health Information Act</i> .				