Consent for Release of Health Information

- [ ] Alberta Hospital Edmonton
- [ ] Community
- [ ] Devon General Hospital
- [ ] Edmonton General CCC
- [ ] Fort Saskatchewan HC
- [ ] Glenrose RH
- [x] Grey Nuns CH
- [ ] Leduc CH
- [ ] Misericordia CH
- [ ] Northeast CHC
- [ ] Redwater HC
- [ ] Royal Alexandra Hospital
- [ ] Stollery Children's Hospital
- [ ] Sturgeon CH
- [ ] University of Alberta Hospital
- [ ] Westview HC

I hereby authorize the above designated facility to disclose my individually identifying health information from the health record specified below in accordance with section 34 of the Health Information Act:

Patient / Resident / Client ______________________________

Surname *First Name*

Personal Health Number ____________________ Date of Birth *(day/month/year)* ____________________

Information to be disclosed: *(please be as specific as possible)* ______________________________

____

____

____

Information to be disclosed to: *(specify name and address of person / agency to whom information is to be disclosed)*: __________

____

____

____

To assist in determining the appropriate information to release, what is the purpose of this disclosure? __________

____

____

I understand why I have been asked to disclose my individually identifying health information, and I am aware of the risks or benefits of consenting, or refusing to consent, to the disclosure of my individually identifying health information. I understand that I may revoke this consent in writing at any time. I understand that I am responsible for any costs that may be associated with this request in accordance with the fee schedule.

This consent expires one year from date of signature. A photocopy or facsimile of this consent shall be as valid as the original.

______________________________ ____________________

Signature of Patient / Resident / Client / Authorized Representative* Date

*Authorized Representative - attach a copy of your authority to act.

____

Signature of Witness