Alberta Health Services

Consent to Disclose Health Information
Health Information Act

The patient/client or his/her authorized representative must complete this form before Alberta Health Services (AHS) may disclose the patient's/client's health information to someone else (unless *Alberta's Health Information Act* authorizes disclosure without consent). For questions on how to complete this form, contact Information & Privacy at 1.877.476.9874 or email privacy@ahs.ca.

Patient/Client Information

☐ Mr ☐ Ms ☐ Dr ☐ Mrs ☐ Miss	Last Name	First Name
Mailing address		
City/Town	Province	Postal Code
Date of Birth *(yyyy-Mon-dd)*	Personal Health Number	

Representative Information

Last Name	First Name			
Organization *(if applicable)*				
Phone	Address	City/Town	Province	Postal Code
Purpose 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) ☐ Nearest relative under Mental Health Act ☐ Agent
☐ Personal representative ☐ Power of Attorney ☐ Written authorization
☐ Specific decision maker

Request Information

Details of Request

What health information do you want to be disclosed? *(e.g. diagnostic tests/results, health charts, EMS reports, etc.)*
Please provide specific details about the health information; such as, if known, the author of the health information and the AHS site /location where it was created.

What is the time period of the health information requested? If known, please provide specific start and end dates

Start Date *(yyyy-Mon-dd)*	End Date *(yyyy-Mon-dd)*

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

Date consent is effective *(yyyy-Mon-dd)*	Expiry Date *(valid for 2 years if no date provided) (yyyy-Mon-dd)*	
Name of person giving consent	Signature	Date *(yyyy-Mon-dd)*

***Personal information on this form is collected under section 20 of the** Health Information Act. **If you have questions about AHS' collection and use of your personal information, contact Information and Privacy at 1.877.476.9874 or email privacy@ahs.ca**.*

Definitions

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 related 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 related 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