Carewest
INNOVATIVE HEALTH CARE

Consent to Disclose Health Information
Health Information Act

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

Section A: Resident/Client Information

Resident/Client Name	
Date of Birth *(YYYY/Mon/DD)*	Personal Health Number

Section B: What health information do you want disclosed?

Please provide details about the health information you want disclosed, such as the name of the Carewest location/facility that provided the health service and the time period of the records.

Section C: What individual/organization is the patient's/client's health information being disclosed to?

Name of Individual/Organization		Phone	
Address	City/Town	Province	Postal Code

Section D: What is the purpose for disclosure?

Please provide the reason why you want to disclose the health information *(required)*.

Section E: Authorized Representative *(required when asking for health information on behalf of another person)*

If you are signing on behalf of the resident/client named in section A, please choose one of the options below and provide a copy of supporting documents.

I, _____(insert representative name), **am**

- ☐ the **parent** or **legally appointed guardian** of the resident/client who is under 18 years of age and who is not a mature minor in relation to their health information.
- ☐ the **guardian** or **trustee** appointed for the adult patient/client under the *Adult Guardianship and Trusteeship Act* exercising my powers or duties as their guardian or trustee.
- ☐ the resident/client's **agent** named in an activated Personal Directive under the *Personal Directives Act* exercising my authority set out in the Personal Directive.
- ☐ the **personal representative** of a deceased resident/client appointed by the resident/client's will or by the Court, administering the patient/client's estate.
- ☐ the resident/client's **named attorney** in a Power of Attorney currently in effect exercising my powers and duties conferred by the Power of Attorney.
- ☐ the resident/client's **nearest relative** selected in accordance with the *Mental Health Act* carrying out my obligations as the nearest relative.
- ☐ the resident/client'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.
- ☐ a **person with written authorization** from the resident/client to act on their behalf.

Section F: What is your relationship to the resident/client?

I am the _____ (insert relationship) and confirm that to the best of my knowledge, I am the nearest relative ranked in order of authority as indicated in the applicable legislation.

Section G: Consent for Disclosure

I authorize Carewest to disclose the resident/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) (valid for 2 years if no date provided)*	
Name of person giving consent	Phone	Email
Signature	Date *(YYYY/Mon/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 resident/client record. If you have questions about the collection and use of any information on this form, contact Health Information Management -403-230-6929.

Office Use Only – 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 Health Information Act.