Clear Form

Covenant Health
Compassionate care led by Catholic values

Patient/Client Name *(Last, First)*
PHN/ULI
Date of Birth *(dd-mmm-yyyy)*

Consent to Disclose Health Information

The patient/client or his/her authorized representative must complete this form before the patient/client's health information may be disclosed to someone else (unless the *Health Information Act* allows for disclosure without consent).

Patient/Client Name *(Last, First)*			
Date of Birth (dd-mmm-yyyy)	Personal Health Number		
Address	City/Town	Province	Postal Code
Details of health information to be disclosed *(Describe in full without abbreviations. Include dates of treatment.)*			
Describe where records are located *(health service provider, hospital, clinic, program)*		City/Town	
Name of person/organization information is to be disclosed to		Phone	
Address	City/Town	Province	Postal Code
Purpose of disclosure		Expiry Date *(dd-mmm-yyyy)* *(valid for 2 years if no date)*	

Authority of person 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 relates to the powers and Duties of the guardian *(or trustee)*
☐ Specific decision maker	-as defined in the *Adult Guardianship and Trusteeship Act*
☐ 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
☐ Nearest relative	-applies only to the nearest relative with obligations under the *Mental Health Act*
☐ Power of attorney	-if access to health information relates to the powers and duties of the attorney
☐ Written authorization	-a person with the patient/client's written authorization to act on the patient/client's behalf

Consent: I authorize Covenant Health to disclose the health information described above. I understand why I have been asked to disclose my health information. I am aware of the risks and benefits of consenting or refusing to consent to the disclosure of my health information to the person/organization specifiedabove. I understand that I may revoke this consent in writing at any time.

Name of person giving consent *(Last, First)*	Signature	Date *(dd-mmm-yyyy)*

The information on this form, together with any copy of a document authorizing a representative to act on behalf of the patient/client is collected under part 3 of the Health Information Act for the purpose of recording the patient/client's consent to the specified disclosure and will be filed on the patient/client's health record. For questions about this collection of information, contact the program area that provided you this form or the Chief Privacy Officer, Information and Privacy at 16940-87 Ave, Edmonton, AB, T5R 4H5 or call 1-866-254-8181.