CROWFOOT VILLAGE
FAMILY PRACTICE

Consent to the Disclosure Of Individually Identifying Health Information

I, _____ _____, authorize of myself to be
*(Clearly print **name of patient**)* *(**Date of Birth**)*

disclosed by (physician) Dr. _____ of Crowfoot Village Family Practice, in accordance with section 34 of the Health Information Act to:

_____ _____ 1 2 3 4 5 6
(Print name of Person you would like to give access) *(Relationship)* *Circle What information access to this person*

_____ _____ 1 2 3 4 5 6
(Print name of Person you would like to give access) *(Relationship)* *Circle What information access to this person*

_____ _____ 1 2 3 4 5 6
(Print name of Person you would like to give access) *(Relationship)* *Circle What information access to this person*

information is being released below:			
#1	Diagnostic, treatment & care information	**#4**	Registration Information
#2	Pick up Form(s) or Letter	**#5**	***NOTIFICATIONS:*** • ***Can leave message on answer machine regarding medication changes (example INR)*** • ***Phone messages for upcoming appointments or Prescriptions ready for pick-up***
#3	Pick up Prescription	**#6**	

I understand why I have been asked to disclose my individually identifying information, and am aware of the risks and benefits if consenting, or refusing to consent, to disclosure of my individually identifying health information.

I understand that, under section 58(2) of the Health Information Act, my express wishes must be considered and I have the right to indicate any portion of my health information that I wish be kept confidential by my physician and not disclosed to others. I may revoke my consent at any time.

Dated this _____ of _____, _____
(Day) *(Month)* *(Year)*

Expiry date (if any)_____ of _____, _____
(Day) *(Month)* *(Year)*

_____ _____
Patient Signature (or Authorized Representative's) *If not patient signing: Source of Representative's Authority/ Relationship*

_____ _____
Witness Signature *Print Witness Name*

CONSENT NOT VALID WITHOUT WITNESS SIGNATURE

BELOW FOR OFFICE USE ONLY:

Section 104 of the *Health Information Act* identifies those individuals who may, on behalf of another individual, exercise the rights and powers conferred on that individual under the *Health Information Act*. Those situations are listed below. **Please check the box that applies to the right by which you are requesting access to health information.**

- ☐ If the individual is 16 years of age or older, by the individual
- ☐ If the individual is under 16 years of age and understands the nature of the right or power and the consequences of exercising the right of power, by the individual
- ☐ If the individual is under 16 years of age but does not meet the criterion in the clause(b), by the guardian of the individual,
- ☐ If the individual is deceased and was 16 years of age or over immediately before death, by the individual's personal representative if the exercise of the right of power relates to the administration of the individual's estate
- ☐ If a guardian or trustee has been appointed for the individual under the Dependents Adults Act, by the guardian or trustee if the exercise of the right of power relates to the powers and duties of the guardian or trustee
- ☐ If an agent has been designated under a personal directive under the Personal Directive Act, by the agent if the directive so authorizes,
- ☐ If a power of attorney has been granted by the individual, by the attorney if the exercise of the right of power relates to the powers and duties conferred by the power of attorney
- ☐ If the individual is a formal patient as defined in the Mental Health Act, by the individual's nearest relative as defined in the Act if the exercise of the right of power is necessary to carry out the obligations of the nearest relative under the Act, or (i) by any person with written authorization