Primary Care Network
GRANDE PRAIRIE

CONSENT TO DISCLOSE HEALTH INFORMATION – *Health Information Act*

The patient or his/her authorized representative must complete this form before Grande Prairie PCN will disclose the patient health information to someone else (unless *Health Information Act* authorizes the disclosure without consent).

Patient/Client Information

Name	
Date of Birth (yyyy-mm-dd)	**Personal Health Number**

What health information do you want disclosed?

Please provide details about the health information you want disclosed, such as the time period of the records and which program delivered the health services.

To what individual/organization is the patient's health information being disclosed?

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

What is the purpose of the disclosure?

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

Authorized Representative (required when asking for health information on behalf of another person)

If you are signing on behalf of the patient named above, please choose one of the options below and provide a copy of supporting documents.

I, _____ , am

- ☐ the parent or guardian of the patient who is under 18 years of age (not a mature minor)
- ☐ the parent or trustee appointed for the adult patient under the *Adult Guardian and Trusteeship Act*
- ☐ the patient's agent named in an activated Personal Directive
- ☐ the personal representative of a deceased patient appointed by the patient will or by the court
- ☐ the patient's named attorney in a Power of Attorney
- ☐ the patient's nearest relative selected in accordance with the *Mental Health Act*
- ☐ the patient'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 patient to act on their behalf

Consent for Disclosure

I authorize Grande Prairie Primary Care Network to disclose the health information described above to the individual or organization(s) identified above. I understand why I have been asked to disclose this health information and I am aware of the risks and benefits of consenting or refusing consent. I understand I may revoke this consent in writing at any time.

Date consent if effective (yyyy-mm-dd)	Expiry date (valid for 2 years if no date provided)

Name of person giving consent	Phone	Email
Signature	Date	