CapitalCare
EDMONTON AREA

CONSENT TO THE DISCLOSURE OF INDIVIDUALLY IDENTIFYING HEALTH INFORMATION

I, _____, authorize the (specified or attached) individually identifying health information:
[Provide as much details as possible on the (a) diagnostic, treatment and care information, (b) registration information or (c) health service provider information to be disclosed. Include specific dates to define the time period of the records. Alternatively, attach copies to this form.]

_____
_____
_____
_____
_____
_____

of myself to be disclosed by CapitalCare, in accordance with section 34 the *Health Information Act* to, _____ (name of recipient), for the following purpose (s):

_____
_____
_____

I understand why I have been asked to disclose my individually identifying information, and am aware of the risks or benefits of consenting, or refusing to consent, to the disclosure of my individually identifying information. I understand that I may revoke this consent at any time.

Dated this _____ of _____, _____.
(day) (month) (year)

Expiry date (if any) _____ of _____, _____.
(day) (month) (year)

_____ _____
Resident[1] or Substitute Decision Maker's Signature Source of Substitute's Authority

_____
Resident or Substitute Decision Maker's Name

_____ _____
Witness Signature Witness Name

[1] Resident refers to resident, elder, patient, participant or client

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For use by interpreter only
This is to verify that I, _____ have
(Name of Interpreter)

interpreted, to the best of my ability, the information contained on the first page of this form to

_____
(Name of client)

And believe that he/she fully understands the implications of signing the document.

Signed: _____ **Date:** _____
(Signature of Interpreter)

Address: _____