CONSENT TO THE DISCLOSURE OF INDIVIDUALLY IDENTIFYING HEALTH INFORMATION

AUTHORIZED BY THE HEALTH INFORMATION ACT (*HIA*), SECTION 34

CLIENT INFORMATION:

Name: _____
(surname) (given name/names)

Date of Birth: _____
(day/month/year)

Address: _____

I authorize my individually identifying health information related to _____

_____
(description of information/relevant dates, etc)

to be disclosed by _____
(name of custodian)

in accordance with section 34 of 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 in writing at any time.

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

_____
Signature of client/authorized representative*

* if you are signing on behalf of the client, the following information must be provided:

_____ _____
Print Name of Authorized Representative **Print** Source of Representative's Authority [refer to *HIA* section 104(1)]

_____ _____
Witness Signature Witness Name

Revised June 6, 2006