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: _____ 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

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