westgrove clinic SPRUCE GROVE

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CONSENT FOR DISCLOSURE OF HEALTH INFORAMTION

I, _____, consent to the release of
(name)

_____
(identify nature of health information)

to_____
(identify individual/organization to whom information is released)

for the purpose of _____.
(indicate how information will be used)

I acknowledge that I have been made aware of the reasons for the disclosure of the above information and the risks and benefits associated with consenting to its release.

I understand that I may revoke my consent at any time, by providing a signed, written statement to that effect.

Date:_____ Valid until:_____

Signature:_____ Print name: _____