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Consent for Disclosure of Health Information
(for minors or incapacitated individuals)

Patient Name: _____ Alberta Health Care # _____

I, _____, consent to the release of
(printed name of guardian or legal representative)

_____
(identify nature of health information)

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

For the purpose of _____
(indicate how the 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.

Signature of Parent/Substitute Decision Maker: _____

Relationship to the Patient: _____

Date: _____ Valid Until: _____