CONSENT TO DISCLOSE HEALTH INFORMATION

Completion of form is required before Natural Health Services Ltd. (NHS) will disclose any health information to a third party.

Section A:

_______________________________ First Name

_______________________________ Last Name

_______________________________ Date of Birth dd-mm-yyyy

_______________________________ Provincial Health Number

Section B:
Please provide details about the health information you want disclosed:

- ☐ Medical Document
- ☐ Intake Questionnaire
- ☐ OTHER (Please Specify) _______________________________
- ☐ Chart Notes
- ☐ Follow-up Questionnaire

Section C:
Name of organization patient health information is being disclosed to.

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Name of Individual/Organization | Phone Number | Fax Number

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Address | City | Postal Code

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Email address

Section D:
Authorized Representative (required when asking for health information on behalf of another person)

*If you are signing on behalf of a patient, please choose one of the options below and provide a copy of supporting documents.

I, _______________________________, am
(insert representative name)

☐ The **parent or legally appointed guardian** of the patient/client who is under 18 years of age and who is not a mature minor in relation to their health information.

☐ The **guardian or trustee** appointed for the adult patient/client under the Adult Guardianship and Trusteeship Act exercising my powers or duties as their guardian or

trustee.

- ☐ The patient/client's **agent** named in an activated Personal Directive under the Personal Directives Act exercising my authority set out in the Personal Directive.
- ☐ The **personal representative** of a deceased patient/client appointed by the patient/client's will or by the Court, administering the patient/client's estate.
- ☐ The patient's **named attorney** in a Power of Attorney currently in effect exercising my powers and duties conferred by the Power of Attorney.
- ☐ The patient's **nearest relative** selected in accordance with the Mental Health Act carrying out my obligations as the nearest relative.
- ☐ The patient/client's **specific decision maker, supportive decision maker, or co-decision maker,** authorized in accordance with the Adult Guardianship and Trusteeship Act carrying out the related duties.
- ☐ A person with written authorization from the patient/client to act on their behalf.

*Additional Comments

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Section E:

I authorize NHS to disclose the patient health information described above to the individual or organization(s) identified above. I understand why I have been asked to disclose my health information and I am aware of the risks and benefits of consenting or refusing to consent. I understand I may revoke this consent in writing at any time.

______________________ Date consent is effective dd-mm-yyyy	______________________ Expiry date dd-mm-yyyy (valid for 1 year if no date provided)
______________________ Name of person giving consent Please Print	______________________ Date dd-mm-yyyy
______________________ Phone	______________________ Signature

Information on this form and the supporting documentation are collected for the purpose of responding to your request and will be filed on the patient record. If you have questions about the collection and use of any information on this form, contact Privacy Officer 403.585.3567.