Consent to Disclose Health Information to an Authorized Representative (HIA)

Protected B (when completed)

The information provided on this form, including the personal health number of the person whose health information is being requested, is collected in accordance with 20(b) of the *Health Information Act* (HIA). This information will be used solely to respond to the access request for health information being made, and will be managed in compliance with the HIA. If you have any questions about the collection and use of your information, please contact the HIA Analyst at Primary and Preventative Health Services Access to Information Office by phone at 780-422-5111, via email at PPHS.infoaccess@gov.ab.ca, or by mail at 19th floor, ATB Building, 10025 Jasper Avenue, Access to Information Office, Edmonton, Alberta, T5J 2B8.

The client or their authorized representative must complete this form before Primary and Preventative Health Services (PPHS) will disclose the client's health information to the client's representative (unless the HIA authorizes disclosure without consent).

Section A: Information about the individual whose health information is being requested ("client")

Last Name

First Name

Date of Birth: Year | Month | Day

Alberta Personal Health Number

Section B: What health information do you want disclosed?

Describe the health information to be disclosed, including relevant dates, programs, records, reports, assessments, or other identifying details.

Section C: Who should receive the health information?

Name of Authorized Representative

Name of Organization (if applicable)

Relationship to the Client

Street Address

City or Town

Province

Postal Code

Phone (home)

Phone (cell)

Phone (business)

Fax

Email Address

Section D: What is the purpose for disclosure?

Describe the purpose of the disclosure.

Section E: Authorized Representative (required when asking for health information on behalf of a client)

If you are signing on behalf of the client named in Section A, please choose one of the options below and provide a copy of supporting documents. (PPHS may require additional documentation to verify your authority to act on behalf of the client.)

- ◯ **I am the parent or legal guardian of a minor under 18 years of age**, the minor is not a mature minor, and there is no court order or other legal restriction that removes or limits my authority to exercise the minor's rights under the HIA. (Mature minor: a person under 18 years of age who is capable of understanding the nature and consequences of decisions about their health information.)
- ◯ **I am the court-appointed guardian of a minor under 18 years of age**, and the minor is not a mature minor.
- ◯ **I am a guardian or trustee appointed under the *Adult Guardianship and Trusteeship Act***, and the requested information is necessary for the exercise of my powers or the performance of my duties as guardian or trustee.
- ◯ **I am the nearest relative under the *Mental Health Act***, and the requested information is required to carry out my responsibilities as nearest relative.
- ◯ **I am an agent acting under an enacted personal directive pursuant to the *Personal Directives Act***, and the requested information is relevant to a decision I am authorized to make on behalf of the client.
- ◯ **I am the personal representative of a deceased individual**, and the requested information relates to the administration of the individual's estate.
- ◯ **I hold a valid power of attorney granted by the individual**, and the requested information relates to the exercise of my powers and duties as attorney.
- ◯ **I have written authorization from the individual (client)**, authorizing me to request health information on their behalf.

Section F: Consent for Disclosure

I authorize PPHS to disclose the health information described in this form to the authorized representative identified above. I understand the purpose of the disclosure and that providing consent is voluntary. I understand that I may refuse to provide consent and that there may be consequences associated with refusing consent. I understand that I may revoke this consent at any time by providing written notice to PPHS, except where action has already been taken in reliance on this consent.

Date Consent is Effective yyyy-mm-dd	Expiry Date yyyy-mm-dd (consent is valid for 2 years if no expiry date is provided)

Name of Individual (Client) Giving Consent, or Authorized Representative if Applicable (Please Print)	Phone

Date yyyy-mm-dd	Signature of Individual (Client) Giving Consent, or Authorized Representative if Applicable