

# ALBERTA HEALTH FACILITIES REVIEW COMMITTEE

590 First Edmonton Place, 10665 Jasper Avenue NW, Edmonton, Alberta T5J 3S9

Phone: 780-427-4924 Fax: 780-427-0806

## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name: \_\_\_\_\_  
(Name of Patient)

Address: \_\_\_\_\_  
(Street) (City/Town) (Province) (Postal Code)

I authorize the following facility(ies), physician(s) or health services provider(s):

(1) \_\_\_\_\_

(2) \_\_\_\_\_

(3) \_\_\_\_\_

to release my individually identifying health information to the:

### **Alberta Health Facilities Review Committee**

The information released may be used for the following purposes: Investigation of a complaint made by me or on my behalf under section 8 of the *Health Facilities Review Committee Act*.

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 to the disclosure of my health information. I understand that I may revoke this consent at any time.

This authorization shall remain valid until the Alberta Health Facilities Review Committee completes its investigation.

Dated this \_\_\_\_\_ of \_\_\_\_\_, 20\_\_\_\_.  
(day) (month) (year)

\_\_\_\_\_  
Patient/Authorized Representative's Signature  
(Circle one)

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Patient/Authorized Representative's Name  
(Please print)

\_\_\_\_\_  
Name of Witness  
(Please print)

\_\_\_\_\_  
Relationship to Patient or Resident  
(If signed by Authorized Representative)

**NOTE: If signed by Authorized Representative, please provide documentation (attach photocopy only) indicating authorization to consent on Patient's behalf (if other than parent of a minor patient).**