PRAIRIE MOUNTAIN HEALTH

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

Please Print:

PART 1: CLIENT INFORMATION

LAST NAME _____ FIRST NAME _____

Date of Birth: Y Y Y Y M M M D D Health Card Number : _____

Address: _____
Mailing Address City or Town Province Postal Code

Phone Numbers: Home: (___) _____ Work: (___) _____ Cell: (___) _____

PART 2: CONSENT TO DISCLOSE THE FOLLOWING PERSONAL HEALTH INFORMATION

_____ may disclose the following specified health information:
Name/Facility/Agency/Organization

_____

_____

_____

To: _____
Name/Facility/Agency/Organization Mailing Address

For the purpose(s) of:

This is a consent to disclose my own information: ☐ Yes ☐ No **If NO – complete Part 3**

PART 3: PERSON PERMITTED TO EXERCISE THE RIGHTS OF AN INDIVIDUAL

LAST NAME _____ FIRST NAME _____

Address: _____
Mailing Address City or Town Province Postal Code

Phone Numbers: Home: (___) _____ Work: (___) _____ Cell: (___) _____

Indicate your authority to act on behalf of the individual: _____

Note: You may be required to provide documentation to prove you have the legal authority to exercise the rights of the individual.

PART 4: SIGNATURE

I understand that this consent may be withdrawn or amended at any time. A withdrawal does not have a retroactive effect. The third party shall not use the personal health information disclosed except for the purpose specified on this consent.

This consent: ☐ is valid for one year ☐ is valid for this request only ☐ expires on Y Y Y Y M M M D D

Signature of person consenting: _____ Date: Y Y Y Y M M M D D