FASD NETWORK | Northwest Central Alberta

P.O. Box 125, Thorhild, AB • Fax: 780-736-2102

Consent to Obtain Information

Name: _____

Date of Birth: mmm/dd/yyyy: _____

Alberta Healthcare #: _____

As per the Health Information ACT (HIA), and the Freedom of Information and Protection of Privacy Act (FOIP), I _____ herby authorize the necessary Departments, Agencies, Services and Organizations to release any of my past and present reports, assessments and medical records as listed below, to NWC FASD Network Adult FASD Clinic Coordinator on behalf of Dr. Vern Naidoo.

Please ensure boxes are checked appropriately

For Continuative Healthcare

- o Birth records, all medical and hospital records
- o Other medical assessments including but not limited to (physicians, occupational therapy, psychological assessments etc.)
- o School Records
- o Government of Alberta Child and Family Services records (adoptive and foster placements, child protection assessments, treatment summaries and parenting assessments etc.)
- o Government of _____ Child Protection and Adoption and/or Foster Services Records.
- o Mental Health & Addictions, and/or Psychiatry Records (addictions)
- o Alberta Justice and Solicitor General Correctional Services (lawyers, probation, correctional facilities, pre-sentence reports, psychological assessments, diagnostic and treatment summaries etc.)
- o Community Health Services/Public Health records.
- o AISH, Income Supports, PDD, FASD Mentors

I fully understand why I have been asked to disclose my individually identifying health information, and I am aware of the risks and/or benefits of consenting or refusing to consent to the disclosure of my individually identifying health information. I understand that I may revoke this consent in writing at any time.

A photocopy or facsimile of this consent shall be as valid as the original.

_____

Print Name | Client or Guardian Signature | Date (mmm/dd/yyyy)

_____

Witness Print Name | Witness Signature | Date (mmm/dd/yyyy)

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Consent to Release Information

I, _____, Date of birth _____
(Full legal name of adult client) (mmm/dd/yyyy)

hereby authorize the Northwest Central Alberta Fetal Alcohol Spectrum Disorder Network to RELEASE the following information verbally or in writing.

This information is to be released to the following identified sources. Please specify the information to be RELEASED by ***circling the corresponding letter*** from list below AND by placing your ***INITIALS*** beside each selected item.

A. _____ All Reports/Correspondence Listed Below
B. _____ Family physician, Psychiatrist, Psychologist
C. _____ Assessment & Diagnostic Services Final Report and Recommendations
D. _____ Psychological Assessment and/or Occupational Therapy Assessment
E. _____ AISH, Income Support, PDD, FASD Advocates
F. _____ Probations, Correctional Facilities, Lawyers, all justice related persons and or facilities

_____ _____
Signature of Client Date (mmm/dd/yyyy)

_____ _____
Signature of Witness Date (mmm/dd/yyyy)

_____
Print Name of Witness

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Consent to Obtain/Release Information

Adult Assessment & Diagnostic Services
Consent to Obtain/Release Information

I, _____, Date of birth _____
(Full legal name of adult client) (mmm/dd/yyyy)

hereby authorize the Northwest Central Alberta Fetal Alcohol Spectrum Disorder Network to OBTAIN/ RELEASE confidential information verbally or in writing for the purpose of coordinating an assessment and diagnosis, developing continuum of care recommendations, and to make appropriate referrals.

This consent form is to be effective for the duration of the client's involvement with the assessment, diagnostic, and intervention services and may be withdrawn by the client at any time during this process.

Name and address of individual/agency(ies) from/for whom information is to be obtained/released:

Northwest Central Alberta FASD Network

_____ _____
Signature of Client Date

_____ _____
Signature of Witness Date

_____
Print Name of Witness

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Date of Birth: mmm/dd/yyyy: _____

Alberta Healthcare #: _____

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_____

Print Name | Client or Guardian Signature | Date (mmm/dd/yyyy)

_____

Witness Print Name | Witness Signature | Date (mmm/dd/yyyy)

Alberta Health Services

Consent to Disclose Health Information
Health Information Act

The patient/client or his/her authorized representative must complete this form before Alberta Health Services (AHS) will disclose the patient's/client's health information to someone else (unless Alberta's *Health Information Act* authorizes disclosure without consent).

Section A: Patient/Client Information

Patient/Client Name

Date of Birth *(yyyy-Mon-dd)*	Personal Health Number

Section B: What health information do you want disclosed?

Please provide details about the health information you want disclosed, such as the name of the AHS location/facility that provided the health service and the time period of the records.

Section C: What individual/organization is the patient's/client's health information being disclosed to?

Name of Individual/Organization			Email	
NWC FASD NETWORK			jennp@nwcfasd.ca	
Address	**City/Town**	**Phone**	**Province**	**Postal Code**
PO BOX 125	THORHILD	(780) 974-7112	AB	T0A3J0

Section D: What is the purpose for disclosure?

Please provide the reason why you want to disclose the health information *(required)*.

CONTINUATIVE HEALTHCARE

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

If you are signing on behalf of the patient/client named in section A, please choose one of the options below and provide a copy of supporting documents.

- ☐ **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.
- ☐ **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.
- ☐ patient/client's **agent** named in an activated Personal Directive under the *Personal Directives Act* exercising my authority set out in the Personal Directive.
- ☐ **nearest relative** of a deceased patient/client as defined in the *Personal Directives Act*. **Also complete Section F.**
- ☐ **personal representative** of a deceased patient/client appointed by the patient/client's will or by the Court, administering the patient/client's estate.
- ☐ patient's **named attorney** in a Power of Attorney currently in effect exercising my powers and duties conferred by the Power of Attorney.
- ☐ patient/client's **nearest relative** selected in accordance with the *Mental Health Act* carrying out my obligations as the nearest relative. **Also complete Section F.**
- ☐ 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.
- ☐ **person with written authorization** from the patient/client to act on their behalf.

Section F: What is your relationship to the patient/client?

I am the _____ *(insert relationship)* and confirm that to the best of my knowledge, I am the nearest relative ranked in the order of authority as indicated in the applicable legislation.

Section G: Consent for Disclosure

I authorize Alberta Health Services to disclose the patient/client's 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 *(yyyy-Mon-dd)*	Expiry date *(yyyy-Mon-dd)(valid for 2 years if no date provided)*

Name of person giving consent *(Please print)*	Phone

Signature	Date *(yyyy-Mon-dd)*

Information on this form and the supporting documentation are collected under the authorization of sections 20 - 22 of the *Health Information Act* for the purpose of responding to your request and will be filed on the patient/client record. If you have questions about the collection and use of any information on this form, contact the Disclosure Help Line at 1.855.312.2265.

Office Use Only - This form is not to be used to document a disclosure or release of information. Information released must be documented in accordance with section 41 of the *Health Information Act*.