ALBERTA HEALTH FACILITIES REVIEW COMMITTEE
250 Garneau Professional Centre, 11044 – 82 Avenue, Edmonton, Alberta T6G 0T2
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)

______________________________ ______________________________
Patient/Authorized Representative's Signature Witness' Signature
(Circle one)

______________________________ ______________________________
Patient/Authorized Representative's Name Witness' Name
(Please print) (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).**

March 2002