APEX MEDICAL CLINIC
Walk-In & Family Practice
5486, Falsbridge Drive N.E. Calgary, AB, T3J 5H4
Ph: (403) 590 4444 Fax: (403) 798 4567
Mon - Fri 8am - 9pm, Sat - Sun 9am - 7.30pm

CONSENT TO THE DISCLOSURE OFINDIVIDUALLY IDENTIFYINGHEALTH INFORMATION*[AUTHORIZED BY HIA s34]*

(Adapted from *Health Information Act: Guidelines and Practices*, Alberta Health and Wellness 2011)

PATIENT INFORMATION

Name: _____
(surname) *(given name/names)*

Date of Birth: _____
(day/month/year)

Address: ____.

I authorize my individually identifying health information related to _____

_____
(description of information / relevant dates, etc.)

to be disclosed by Dr. _____ of Apex Medical Clinic INC.

in accordance with section 34 of the Health Information Act to,

_____
(Identify individual/organization to whom information is released)

for the following purpose(s): _____
(indicate how information will be used/disclosed)

_____

I acknowledge that I have been made aware of why I have been asked to consent to the disclosure of the above information, and am aware of the risks and benefits associated with consenting, or refusing to consent, to the disclosure of my individually identifying health information. I understand that I may revoke my consent at any time, by providing a signed, written statement to that effect.

Dated this ____ of _____, _____. Expiry date: ___ of _____, _____
(day) (month) (year) (day) (month) (year)

_____
Signature of patient / authorized representative*
* if you are signing on behalf of the client, the following information must be provided:

_____ _____
Print Name of Authorized Representative **Print** Source of Representative's Authority [refer to *HIA* section 104(1)]

_____ _____
Witness Signature Print Witness Name