calgary health region

Site: _____

Consent to Disclose Health or Personal Information

I, _____, authorize

☐ the Calgary Health Region OR ☐ Other _____

to disclose the following health or personal information: _____

This information may be disclosed to _____

for the following purpose(s) only: _____

I understand why I have been asked to disclose this information and am aware of the risks or benefits of consenting or refusing to consent to disclose this information. I also understand that I may revoke this consent at any time by submitting a written revocation document to the Calgary Health Region.

Please choose one of the following:

☐ Expires _____ **OR** ☐ Does not expire except by my written revocation to Calgary Health Region

Dated this _____ of _____, _____

Patient, Client or Legal Representative's Signature	Legal Representative's Name (attach documents)
Witness Signature	Witness Name