CROWFOOT VILLAGE
FAMILY PRACTICE

CONSENT TO DISCLOSE FORM

NAME: (printed)_____

DOB: (YMD) _____

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

Name of individual or organization information can be disclosed to:	Phone number or address if applicable:
	Check all that apply below ✓
Diagnostic, treatment and care information	
Pick up form(s) or letter(s)	
Demographic Information (contact information, Alberta Health Care Number)	
Notifications: This means CVFP can leave a message on the answering machine with health information or appointment confirmation	

I authorize CVFP to disclose my 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.

When a CVFP patient turns 16, they will need to sign consent for their parents/guardians to be able to access their medical information.

Mature Minor
When a child has reached the point where he or she has sufficient intelligence and understanding to appreciate the nature and consequences of what treatment or therapy is proposed, the individual is considered a **mature minor**. A mature minor can request their information not be disclosed. This would be at the agreement of the mature minor and the custodial physician.

Date consent is effective (YMD)	Expiry date: (if any) YMD
Signature:	Date (YMD)

:Feb 8th, 2021