Covenant Health

Authorizing a Representative

Health Information Act

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

Patient/Client Information		
☐ Mr ☐ Ms ☐ Dr ☐ Mrs ☐ Miss	Last Name	First Name
Mailing Address		
City/Town	Province	Postal Code
Date of Birth *(yyyy-Mon-dd)*	Personal Health Number	

Representative Information		
Last Name	First Name	
Organization *(if applicable)*		
Mailing Address		
City/Town	Province	Postal Code

Representative is authorized to: ***(check one)***

☐ Exercise all my rights under the *Health Information Act*
☐ Exercise my rights to access all my records containing my health information
☐ Exercise my right to access only the following records containing my health information *(describe)* _____

_____

☐ Other *(describe in detail)* _____

_____

_____

_____

I confirm that my representative has the authority to carry out the above rights and responsibilities on my behalf.

Name *(Print Last Name, First Name)*	Signature
Date *(yyyy-Mon-dd)*	Expiry Date *(optional) (yyyy-Mon-dd)*

Witness Last Name	Witness First Name	Witness Signature

Personal information on this form is collected under section 20 of the Health Information Act. COV is collecting the personal health number as a custodian under Section 21(1) of the Health Information Act. If you have questions about the collection and use of any information on this form contact Information and Privacy at 1-866-254-8181.