

Authorization for Release of Information

I understand my signature on this release will allow the College of Physicians & Surgeons of Alberta to:

1. obtain medical records or other information, as specified in the attached letter, relevant to my complaint issue(s) (medical records include person identifiable information, diagnostic, treatment and care documentation);
2. provide a copy of my complaint to the physician(s) named and all other persons providing information;
3. disclose, where applicable, information concerning my complaint including person identifiable information, diagnostic, treatment and care information to the person making the complaint on my behalf;
4. use this original form for faxing/photocopying to collect information from physicians and facilities and the copy of this form shall be as valid as the original;

in order to investigate certain matters under the *Health Professions Act*.

This will authorize the release of records, including medical information or otherwise, concerning

Print Patient's Full Name

Date of Birth

I understand why I have been asked to consent to the disclosure of this information and am aware of the risks or benefits of consenting, or refusing to consent, to disclose this information. I also understand that this consent is valid for a two-year period past the date signed and that I may revoke this consent in writing at any time.

Signature of Patient or Legal Representative*

Date Signed

Print Witness's Full Name
(person who witnessed signature of patient or legal representative)

Signature of Witness

Date Signed by Witness

**(If you are the legal representative of the patient, please provide legal documentation authorizing your signature. Examples include: Executor/Executrix or administrator of an estate, legal guardian, etc.)*

Print, sign and mail this form along with the Complaint Reporting Form to the College. Print or save a copy for your records.