SECTION 34 CONSENT PURSUANT TO THE HEALTH INFORMATION ACT

Disclosure of Health Information

I, **_____ (name of Patient)** authorize my personal individually identifying:

Nursing Care Plan & Treatment Record (which may cite external diagnostic, treatment and care information, registration information, and health services provider information*)

of **CONSORTIA HEALTH CARE INC.** to be disclosed by **ADAM HENLEY, RN** in accordance with section 34 the *Health Information Act* to

_____

(name of recipient(s), address)

for the following purpose(s):

_____.

I acknowledge that I have been made aware of the reasons for the disclosure of the above information, and the risks and benefits associated with consenting to its release.

I understand that I make revoke my consent at any time, by providing a signed, written statement to that effect.

Dated this ____of _____, _____. Expiry date (if any) ____of _____, _____.
(day) (month) (year) (day) (month) (year)

_____

Signature of Patient

_____

Printed Name of Patient

_____

Signature of Witness

_____

Printed Name of Witness