Western Health

CONSENT TO DISCLOSE/OBTAIN INFORMATION

I, _____ give permission to Western Health to:
(Full Name)

(check relevant box(es) ❑ Obtain information from

❑ Disclose information to

_____
(Name of Service Provider) (Department) (Agency/Organization)

regarding _____
(Describe specific information)

as it relates to: **Name(s)** _____

Date of Birth _____
(YYYY/MM/DD)

MCP _____

This information will be used for the purpose of _____

_____
(State reason for which information is being used)

I am giving this permission of my own free will and it is only valid for a _____ period (maximum one year). I may cancel my consent at any time by contacting my service provider in writing. This consent only applies to the people or group named above. I understand that no other information will be given to any other persons without my written permission unless.

a. it is authorized by law;
b. it is to a person involved with my treatment or care in an emergency situation.

Date: _____

_____ _____
Signature of person giving consent Service Provider

_____
Relationship (to client/patient/resident)