Regional Fertility Program
The Prelude Network

400,2000 Veteran's Place NW
Calgary, AB T3B 4N2
403.284.5444
regionalfertilityprogram.ca

CONSENT FOR THIRD PARTY DISCLOSURE OF MEDICAL INFORMATION AND/OR USE OF LANGUAGE INTERPETERS

Patient Name	Partner Name
Address	Address

I/We authorize the Regional Fertility Program to disclose and release my health information described below to:

_____ _____
Name Relationship

_____
Address

_____ _____
Telephone number Email

For the purpose of _____

Health Information to be disclosed:

- ☐ Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing for all conditions
  OR
- ☐ Disclose my health record as above, **BUT do not disclose** (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify): _____

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. Information that is disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by the *Health Information Act*. I understand that this consent is effective immediately on the date that this consent is signed and valid for an indefinite period unless I inform the Regional Fertility Program in writing. I am aware that I may revoke this consent in writing at any time.

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Patient: _____
Print Name *Signature*

Partner: _____
Print Name *Signature*

Witness: _____
Print Name *Signature*

Date: _____
(YYYY-MM-DD)