M.D. of Willow Creek
Box 550
Claresholm, AB
T0L0T0
www.mdwillowcreek.com

Consent to Disclose Personal Information

Protection of Privacy Act (POPA)

SECTION A: Individual Information	
Please note you are the individual who is the subject of the personal information to be disclosed.	
Last Name:	**First Name:**

SECTION B: What personal information do you want disclosed
Please provide details about the personal information you want disclosed and the time period of the records.

SECTION C: What individual/organization is the individual's personal information being disclosed to?			
Name of individual/Organization:		**Phone Number**	
Address:	**City/Town:**	**Province:**	**Postal Code:**

SECTION D: Authorized Representative ***(required when asking for personal information on behalf of another person)***

If you are signing on behalf of the individual named in section A, please choose one of the options below and provide a copy of supporting documents.

I, ____, am
(insert representative name)

☐ the personal representative of a deceased individual appointed by the individual's will or by the court, administering the individual's estate.

☐ the guardian or trustee appointed for the individual under the *Adult Guardianship and Trusteeship Act* exercising my powers or duties as their guardian or trustee.

☐ the individual's agent named in an activated Personal Directive under the *Personal Directives Act* exercising my authority set out in the Personal Directive.

☐ the individual's named attorney in a Power of Attorney currently in effect exercising my powers and duties conferred by the Power of Attorney.

☐ the parent or legally appointed guardian of the individual who is under 18 years of age and who is not a mature minor in relation to their personal information.

☐ a person with written authorization from the individual to act on their behalf.

SECTION E: Consent for disclosure

I authorize the MD of Willow Creek to disclose the personal information described above to the individual or organization (s) identified above. I understand why I have been asked to disclose my personal information and I am aware of the risks and benefits of consenting or refusing to consent. I understand I may revoke this consent in writing at any time.

Date consent is effective (yyyy-mm-dd):	**Expiry date (yyyy-mm-dd) (valid 2yrs if not dated):**	
Name of person giving consent:	**Phone:**	**Email:**
Signature:	**Date (yyyy-mm-dd):**	

The collection of your personal information on this form and the supporting documents is legally authorized by section 4 (c) of the Protection of Privacy Act (POPA). Your information will only be used and disclosed as necessary for responding to your request. If you have any questions about the collection of your personal information as provided on this form, please contact us.

MD of Willow Creek - Privacy Head - Box 550 Claresholm, AB T0L0T0 / 403-625-3351 / md26@mdwillowcreek.com