cpsa
COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

Consent to Release Information

I understand my signature on this release will allow the College of Physicians & Surgeons of Alberta (CPSA) to do the following in order to investigate certain matters under the *Health Professions Act*:

1. **Get** medical records or other information about my complaint issue(s). Note: medical records include person identifiable information, diagnostic, treatment and care documentation.
2. **Give** a copy of my complaint to the physician(s) named and all other persons who provide information.
3. **Share**, 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** copies of this signed authorization form to collect information from physicians and facilities.

This form authorizes the release of records, including medical information or otherwise, concerning:

Print Full Name of Patient	Date of Birth (day/month/year)	AB Health Care #

I understand why the CPSA has asked for my consent to share my information, and I am aware of the risks or benefits of consenting, or refusing to consent. I also understand my consent is valid for a two-year period from the date signed, and that I can revoke this consent in writing at any time.

Print Full Name of Patient or Legal Representative*

Signature of Patient or Legal Representative* | Date signed (day/month/year)

Print Full Name of Witness

Signature of Witness | Date signed (day/month/year)

**If you are the legal representative of the patient, please provide proof of guardianship, or if the patient is deceased, a copy of the will naming you as Executor/Executrix.*

File Number: _____ (CPSA Use Only)