CONSENT TO ACCESS AND RELEASE INFORMATION

In order to process a complaint pursuant to the *Health Professions Act*, it is necessary to access information which includes confidential personal and medical information.

Physicians or other medical providers involved in the care or treatment outlined in the complaint form **must** be able to directly access, view and obtain copies of medical records and personal information so as to respond to the CPSA.

The CPSA **must** be able to access, view and provide copies of medical records to relevant parties in an effort to process the complaint.

Medical Records include: person identifiable information, diagnostic, treatment and care information, medical charts/notes, office records, emails/texts, correspondence, phone and video recordings.

This form is specific to the following individual:

Print Full Name of Patient: _____

Date of Birth of Patient: Day _____ Month _____ Year _____

AB Health Care Number: _____

I, _____ am the (check one)

[☐] Patient named above

or

[☐] Legal Representative of the Patient named above

I am providing my consent and authorization as follows:

1. **Authorize** the physician(s) named in the complaint Form to access, view, and make copies of the relevant medical records and provide copies of same to the CPSA in response to the complaint.
2. **Authorize** the CPSA to access, view, gather, copy, and distribute relevant medical records as required to process the filed complaint.
3. **Give** a copy of the complaint form (and any additional information/attachments) to the physicians(s) or other respondents named in relation to the complaint.
4. **Share** where applicable, information concerning the complaint including personal information and medical records to other parties involved in the complaint process including but not limited to: responding individuals, legal counsel, CPSA investigators, CPSA review or hearing committee members, external investigators, and experts.

5. **Accept** both wet signature and digitally signed through DocuSign electronic signature processing for this release.
6. **Use** copies of this signed release form to access, view, collect, copy, and share information including allowing physicians and/or other respondents to directly access medical records where they may not be the custodian of such records for the purpose of processing the complaint.

I understand why the CPSA has asked for my consent to the above and I am aware of the risks or benefits of consenting, or refusing to consent.

I also understand that my consent is valid until this complaint is closed by CPSA, and that I can revoke this consent in writing at anytime.

Signature of the Patient | Date Signed

_____ _____

OR

Signature of the Legal Representative* | Date Signed

_____ _____

*Legal Representatives must provide copies of legal authority to act on behalf of the patient.