arbi making life better
Association for the Rehabilitation of the Brain Injured

CONSENT FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

(This form must be completed in ink)

1. In situations other than those specifically excluded in Section 24 of the Alberta Hospitals Act, this form must be signed by the patient/guardian/or other legally authorized party prior to releasing and/or obtaining information about him/her.

2. When requesting information, this form must be accompanied by a covering letter which indicates what information is requested.

RE: _____
(Print client's name)

I, _____, hereby authorize Association for the
(Print client/guardian's name)

Rehabilitation of the Brain Injured (ARBI) to:

1. Obtain health information and/or medical records from hospitals, rehabilitation centers, care centers, physicians or other health care personnel and other service providers, subject to the following exclusions, if any, _____

2. Release health information and/or medical records to referring hospitals, rehabilitation centers, care centers, physicians, other health care personnel and/or service providers, subject to the following exclusions, if any _____

3. To provide or use a photocopy/fax copy of this release.

_____ _____
Signature client/guardian Date

_____ _____
Signature of witness Date

This consent remains valid: ☐ from_____to_____
Date Date
☐ **until reassessment/team meeting.**