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

CONSENT FOR RELEASE OF CLIENT INFORMATION WITH CARE PROVIDERS

I, _____, am hereby in agreement with
(Client/Guardian Name)

Association for the Rehabilitation of the Brain Injured (ARBI) sharing client information with care providers for _____
(Client Name)

related to the client's health and wellbeing.

_____ _____
Signature of Client/Guardian Date

_____ _____
Signature of Witness Date

This consent remains valid for three (3) years

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

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.

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

RE: _____
(Client Name)

I, _____, hereby authorize Association for the
(Client/Guardian 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. Provide or use a photocopy/fax copy of this release

_____ _____
Signature of Client/Guardian Date

_____ _____
Signature of Witness Date

This consent remains valid for three (3) years