



DECLARATION OF SUBSTITUTE DECISION MAKER STATUS

This form is to be completed by individuals declaring their status as substitute decision makers for the purpose of submitting an access to information request under the *Health Information Privacy and Management Act* on behalf of another individual.

You MUST attach the Physician Affirmation form to this form.

Section 1: Individual for whom records are being requested (the "Individual")		
Full name of individual whose information is sought		
Section 2: Substitute decision maker information		
Full name of substitute decision maker		
Residential address		Territory/Province
Relationship to the Individual <input type="checkbox"/> Guardian and have authority to give the consent <input type="checkbox"/> Spouse <input type="checkbox"/> Child (other than a minor child) <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Brother or sister (other than a minor) <input type="checkbox"/> Other relative <input type="checkbox"/> Close friend <input type="checkbox"/> Custodian and health care provider		
Section 3: Declaration		
I declare that the information provided above is accurate and complete.		
<input type="checkbox"/> I understand that section 121(1)(c) of the <i>Health Information Privacy and Management Act</i> provides that a person who knowingly makes a false assertion to the effect that the person is entitled to consent on behalf of another individual is guilty of an offence and on conviction is liable to a fine of up to \$25,000.		
Signature of declarant	Printed name of declarant	Date YYYY/MM/DD