



CONSENT TO RELEASE OF INFORMATION

This form is to be completed by individuals consenting to the disclosure of their personal health information held by the Department of Health and Social Services to another individual.

Section 1: About you (individual for whom records are being requested)		
First name	Last name	Date of birth YYYY/MM/DD
Address		
Section 2: Information/records requested		
Identify the information held by Health and Social Services for which you are consenting to be released.		
Unless previously revoked by me, this consent to the release of the information specified above expires on YYYY/MM/DD		
Section 3: Contact information of the individual being given consent		
First name	Last name	
Phone	Email	
Address		
Section 4: Signature of individual for whom records are being requested		
I declare that my consent to the release of the information specified above has been given voluntarily. I understand that I may withdraw this consent at any time.		
Signature	Print name	Date YYYY/MM/DD
Signature of parent or guardian (if required)		
Section 5: Signature of witness		
Signature	Print name	Date YYYY/MM/DD

Information contained in this form is collected, used and disclosed in accordance with Yukon's *Health Information Privacy and Management Act* and other applicable laws. A written statement of Health and Social Services information practices can viewed at www.yukon.ca/healthprivacy or by contacting the department's Privacy Officer at healthprivacy@yukon.ca.