Alberta Health Services

EDUCATION AND PROMOTION
CONSENT TO USE AND DISCLOSURE OF PHOTOGRAPH
AND OTHER PERSONAL AND HEALTH INFORMATION

I, _____ (name of patient) hereby consent to my personal information (including a photographic image or images of myself) and/or my individually identifying health information being:

(a) used by Alberta Health Services in accordance with:
- (i) section 39(1) of the *Freedom of information and Protection of Privacy Act of Alberta ("FOIP"):* and/or
- (ii) sections 27(1)(a) and 27(2) of the *Health Information Act* of Alberta *("HIA")*; and/or

(b) disclosed by Alberta Health Services to _____ (name of recipient) in accordance with:
- (i) section 40(1) of *FOIP,* and/or
- (ii) section 34 of *HIA,* in the form of (check all that apply):

- ☑ Still/digital Photographs
- ☑ Video recordings (with or without sound)
- ☑ Sound recordings
- ☑ Writing

□ Other _____

for the following purpose(s) (check all that apply):

- ☑ Media release/interviews
- □ Education
- ☑ Presentations
- ☑ Alberta Health Services website (accessible nationally and internationally)
- ☑ Publications
- ☑ Promotions
- ☑ Hospital displays

☑ Other AHS Social Media

□ (Check and complete if applicable): I confirm that Alberta Health Services may use my name, address and telephone number for the purpose of contacting me to discuss any changes in circumstances which may be relevant to the consent. My address and telephone number is as follows:

_____
_____

Other relevant information/conditions: _____
_____
_____

I acknowledge that I have been made aware of the reasons that my personal information (including a photographic image or images of myself) and/or individually identifying health information is needed and the risks and benefits of consenting, or refusing to consent, to the use and /or disclosure of the same. I understand and confirm that I may revoke this consent at any time.

I release and discharge Alberta Health Services and those for whom each is responsible at law, from all responsibility and liability for the content of the above mentioned still/digital photographs, video recordings and/or sound recordings and the specific use to which they may be applied. I declare that this release and discharge shall be binding upon my heirs, executors, administrators and assigns.

I understand that I have the right to refuse to grant this consent.

This consent is effective this _____ (day) day of _____ (month), 20____ (year) and (if applicable)
expires on the _____ (day) day of _____ (month), 20____ (year).

_____
Signature of Patient or Authorized Representative

_____
Source of Representative's Authority
(if applicable, attach copy of authoritative document)

_____
Printed Name of Patient or Authorized Representative

_____
Signature of Witness
(Print Name of Witness_____)

Information on the form is collected under the authority of section 33(c) of FOIP and/or section 20(b) of HIA [pursuant to sections 27(1)(a) and 27(2) of HIA] for the purposes of providing health services and carrying out planning and resource allocation, health system management, public health surveillance and health policy development. Alberta Health Services may disclose health information on a routine basis to other custodians for approved purposes as authorized by HIA. For more information about the collection of information on this form, please contact Alberta Health Services – Edmonton Area at 780-4077208.