Lethbridge School Division
433 – 15 Street South
Lethbridge, Alberta T1J 2Z5
Phone: (403) 380-5300 Fax: (403) 327-4387

805.6.13

General Release of Information

CONSENT TO THE DISCLOSURE OF INDIVIDUALLY IDENTIFYING HEALTH/EDUCATION INFORMATION

(AUTHORIZED BY SECTION 34 OF THE *HEALTH INFORMATION ACT*)

This form is to be completed by the child's parent or legal guardian, or independent student, to authorize the release of information relevant to the student's personal growth.

A signed General Release of Information must be completed for **EACH** agency, school, or professional and the original must be forwarded to the appropriate agency or professional (referred to "custodian" below).

I,_____(Parent/Guardian/Independent Student), authorize individually identifying

☐ diagnostic, treatment and care information
☐ registration information
☐ health services provider information
☐ cumulative file/student record
☐ Other: _____

on behalf of _____ (Name of Student) to be disclosed by _____(name of custodian), in accordance with section 34 the *Health Information Act* to Lethbridge School Divison for the following purpose (s) _____.

Student Information

Student: Last Name/First Name _____

Alberta Learning Student Identification No. _____ Date of Birth: _____

School: _____ Grade/Class: _____

I understand why I have been asked to disclose my individually identifying information, and am aware of the risks or benefits of consenting, or refusing to consent, to the disclosure of my individually identifying information. I understand that I may revoke this consent at any time.

Dated this _____ of _____, _____.
(day) (month) (year)

Expiry date (if any) _____ of _____, _____.
(day) (month) (year)

_____ _____
Parent/Guardian/Independent Student Name Parent/Guardian/Independent Student Signature

_____ _____
Witness Signature Witness Name