# Release & Consent for Use & Disclosure of Protected Health Information

**[This is a sample only - modify as appropriate]**

To [custodian of records]:

I authorize you to disclose/release my medical records to the Successor Lawyer named below as my agent. This includes all health information and medical records regarding any past, present or future physical or mental health condition.

Successor Lawyer Name:

Address:

Phone number: Email:

I intend for [Successor Lawyer] to be treated as I would be with respect to my rights regarding the use and disclosure of my health information and other medical records.

This release authority applies to any information governed by the *Health Information Act* and the *Freedom of Information and Protection of Privacy Act.*

I authorize any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services to give, disclose, and release this information to my agent, without restriction.

This authorization supersedes any prior agreement I may have made with my health care providers to restrict access to or disclosure of my health information. The authority given to my agent has no expiration date and expires only in the event that I revoke the authority in writing and deliver it to my health care provider.

Any information provided to [Successor Lawyer] may be used/disclosed to assist in the determination of my mental or physical capacity to practice law.

I confirm that I have authority to sign this document and authorize the use or disclosure of protected health information, and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Executed in the \_\_\_\_\_\_\_\_\_\_[City/Town] of in the Province of .

Signature: Date:

Name:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Number (optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_