Living with Advanced Illness Centre

# Consent to Release & Receive Information

I, _____ of
(Name of Hospice Calgary Client/Parent/Custodian)

Address: _____

give consent to Hospice Calgary Society counselling staff to disclose or collect personal information about myself/my family from the following individuals or groups:

Alberta Health Services: _____

Physician: _____

Palliative (Home) Care Team: _____

School: _____

Psychiatrist: _____

Psychologist: _____

Child & Family Services: _____

Community Agency: _____

Other: _____

I understand the reason for disclosing or collecting personal information is for coordinated support for myself/my family and that there are risks and benefits associated with this process.

I understand that I may cancel this consent in writing at any time, and no other information will be disclosed or collected from the stated sources thereafter.

This consent is effective until a decision is reached that support from Hospice Calgary will be terminated.

_____ _____
Client/Parent/Custodian Signature Date

_____ _____
Counsellor Name Counsellor Signature