PCN WELLNESS CENTRE
4000, 1800 – 194 Avenue SE
Calgary, AB T2X 0R3
Ph: 403-668-8600 Fax: 504-668-8610

FORM
Involvement of Others

Primary Care Services | V1.0 | 15 Jul 2021

Name (last, first)	
Birthdate (yyyy-Mon-dd)	Gender ☐ M ☐ F
PHN (Health Care #)	

Instructions: If the person providing consent disagrees to an item on this consent form, strikeout the text and have them initial beside it.

This form is used for the purpose of authorizing someone other than the patient to communicate with our staff regarding your medical information, including booking appointments and receiving phone updates.

Signing this form means that you consent to us to verbally or through secure text/email (Brightsquid) share personal health information with those you designate. We will require a separate consent to release paper copies of health records, as there are sometimes fees associated with these requests.

This agreement will apply to any services offered at the PCN, which will include the Time to Talk (T2T) Therapy program, Social Work, Nutrition Services, Pain Program, and Family Care (primary care practice). Please indicate any exceptions below:

In addition, specify what information is to be shared:

☐ All information

☐ Only regarding the following subject: _____

☐ All information except for the following subject: _____

The person listed below is authorized to access my health information:

Name of person	Phone number
Address	Relationship to patient

This authorization will remain in effect until revoked by you. If you wish to limit the duration of this authorization, please specify: _____ *(end date)*

Name of person(s) providing consent	Phone Number(s):	Specify role of person(s) providing consent:
(1) (2)	(1) (2)	☐ Patient (adult) ☐ Guardian ☐ Patient (mature minor)

Signature of person(s) providing consent	Date *(yyyy-Mon-dd)*	Time
(1) (2)	(1) (2)	(1) (2)

Note: When an individual other than the patient provides consent, a copy of the court order, personal directive, or other document authorizing them to do so must be kept on the health record.

Witness Statement			
I observed the person providing consent sign the consent form (witness must be at least 18 years of age).			
Name	Signature	Date *(yyyy-Mon-dd)*	Time

Clinician Statement			
I have explained the treatment/procedure or service to the person providing consent. In my opinion, this person understands the nature, benefits, risk, consequences, and alternatives. Consent was given via ☐ Written ☐ Telephone ☐ Videoconferencing			
Name	Signature	Date *(yyyy-Mon-dd)*	Time