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Alberta Aids to Daily Living (AADL) Program

This form is used to obtain consent from the client to allow Alberta Health, Alberta Blue Cross, and Alberta Health Services to disclose the client's personal/health information to the AADL vendors/specialty suppliers or authorizers. Information on this form is being collected /used pursuant to sections 20(b) and 27 of the Health Information Act (HIA), section 33(a) & (c) of the Freedom of Information and Protection of Privacy Act (FOIP Act) for the purpose of obtaining an Alberta Aids to Daily Living benefit. If you have questions about the collection of your information, you can contact the Alberta Aids to Daily Living Program at Telus House, 13th Floor, 10020 100 Street NW, Edmonton, AB T5J 0N3; Telephone: 780-427-0731, Fax:780-422-0968.

TERMS AND CONDITIONS

- 1. This declaration must be completed and signed before any order can be placed. A copy must be kept on file at the specialty assessor/authorizer site.
2. If the client is unable to sign, please provide the name and phone number of the individual who is financially responsible for this client (Minor: Parent/Legal Guardian. Adult: Informal Trustee/Enduring Power of Attorney/Legal Trustee).

Collection of Personal Information

I authorize my individually identifying personal and health information related to my eligibility for Alberta Aids to Daily Living (AADL) benefits to be disclosed by Alberta Health, Alberta Blue Cross and Alberta Health Services, in accordance with section 40(1)(d) of the Freedom of Information and Protection of Privacy Act, section 7(2) of the FOIP regulations and section 34 of the Health Information Act to approved AADL vendors/specialty suppliers or authorizers for the provision of and billing for AADL benefits.

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 in writing at any time by contacting the Alberta Aids to Daily Living Program using the contact information at the top of this form.

Please check off the Yes or No box on the bottom of this form. If the client is unable to check off the box, the individual signing on behalf of the client must do so.

- I have read and understand the Terms and Conditions above.
I understand this Client Declaration must be completed and signed before any order can be placed.

Note: If the client is unable to sign, provide the name and phone number of the individual who is financially responsible for this client (Minor: Parent/Legal Guardian, Adult: Informal Trustee/Enduring Power of Attorney/Legal Trustee). This individual is also required to sign and print their name on this form on behalf of the client.

Signature of Client/Individual for client Name (Please PRINT) Relationship to Client

Date Phone Number (if not client)

I consent to the use of my personal information for quality monitoring and program improvement, which may include telephone, mail, or web-based surveys. All personal information will be protected in accordance with the provisions in Alberta's Health Act and Freedom of Information and Protection of Privacy Act (FOIP).

Yes No