Alberta Health Services

Authorizing a Representative Information

Freedom of Information and Protection of Privacy (FOIP) Act

The applicant or their authorized representative must complete this form before Alberta Health Services may disclose the applicant's response and associated records to someone else (unless Alberta's *Freedom of Information and Protection of Privacy Act* authorizes disclosure without consent).

Applicant Information		
☐ Mr ☐ Ms ☐ Dr ☐ Mrs ☐ Miss	Last Name	First Name
Organization *(if applicable)*		
Mailing address		
City/Town	Province	Postal code

Representative Information		
Last Name	First Name	
Organization *(if applicable)*		
Mailing address		
City/Town	Province	Postal Code

Representative is authorized to: *(check one)*

☐ Exercise all my rights under the *Freedom of Information and Protection of Privacy Act*
☐ Exercise my right to access all my records contained in my request
☐ Exercise my right to access only the following records contained in my request *(describe)* _____

☐ Other *(describe in detail)* _____

I confirm that my representative has the authority to carry out the above rights and responsibilities on my behalf.

Name *(Print Last Name, First Name)*		Signature
Date *(yyyy-Mon-dd)*		Expiry Date *(Optional) (yyyy-Mon-dd)*
Witness Last Name	First Name	Witness Signature

The collection of your personal information on this form is legally authorized by section 33 (c) of the Freedom of Information and Protection of Privacy Act (Alberta). Your information will only be used and disclosed as necessary for responding to your request. If you have any questions about the collection of your personal information as provided on this form, please contact a Privacy Advisor by emailing privacy@ahs.ca, or send your questions in writing by prepaid mail addressed to the attention of Information & Privacy at Seventh Street Plaza 5th Floor North Tower 10030-107 Street Edmonton AB T5J 3E4.