

**Consent to Participate in Edmonton Mental Health Court and  
Consent to Disclose Personal Information and Health Information**

Participant:	
DOB:	
PHN (if known):	
Address:	
Contact #:	

**Why am I Being Asked to Sign This Consent?**

I am choosing to participate in the Edmonton Mental Health Court (the “**Court**”) freely and voluntarily.

In order to participate in this Court, I consent to the access, use and disclosure of some health information and personal information about me by and to the Court, a psychiatrist who assists the Court, and my defense counsel/duty counsel if I am represented by counsel. For example, this may include information about a diagnosis received related to my mental health.

My health information and personal information will be disclosed for these purposes:

- 1) helping duty counsel or my defence counsel to more effectively represent me in Court; and
- 2) helping the Judge make appropriate decisions about me.

If I am represented by defence/duty counsel, I understand that my personal information and health information will only be disclosed to the Court in circumstances in which my defence/duty counsel has agreed that it can be disclosed.

**What Type of Personal Information or Health Information Will be Shared?**

I authorize the following types of personal and health information to be accessed, used and disclosed by and to defence/duty counsel, the psychiatrist assisting the Court and the Court:

- 1) Updated contact information and emergency contact information;
- 2) Current and past health information, including clinical records held by health or mental health and addictions providers and programs, regarding my clinical diagnosis, tests, evaluations or assessments, and treatment;
- 3) Current and past information from other community programs or agencies with whom I have applied for and/or received services.

Original to: Alberta Health Services

Copies to: Covenant Health, if information is requested from Covenant; and if requested, to Participant and/or Defense Counsel or Duty Counsel.

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**Which organizations can disclose my personal information or health information?**

I authorize the following organizations to disclose my personal information or health information for the purposes set out in this form, and I understand that this form will be provided to them:

- Alberta Health Services – Hospitals, Addictions and Mental Health, Corrections Health, Corrections Transition Team, Diversion Program, and Northern Alberta Forensic Psychiatry Services, including Alberta Hospital Edmonton and Forensic Assessment & Community Services
- Covenant Health – Hospitals, and Addictions and Mental Health
- In addition to accessing its own databases, Alberta Health Services or Covenant Health can disclose information about me from Alberta Netcare (this includes information from the Pharmacy Information Network)

Other \_\_\_\_\_

**Acknowledgement**

I understand why I am consenting to the disclosure of my health information while participating in Mental Health Court. I am aware of the risks and benefits of consenting, or refusing to provide my consent. In particular, I understand that all courts, including Mental Health Court, are open to the public, and that documents that are filed in a court are generally a matter of public record.

**Revoking (Withdrawing) Consent**

I understand I may revoke this consent in writing at any time. If I do this, then the organizations listed above cannot disclose any personal or health information, as of the date that they receive the document in which I revoke my consent. I understand that this does not apply to any disclosure of information that took place before I revoked my consent.

This consent shall remain valid for as long as I am a participant in Mental Health Court, unless otherwise specified or withdrawn.

A photocopy, facsimile or electronic copy of this form shall be deemed as valid as the original.

Dated at Edmonton, AB, this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_. \*

\_\_\_\_\_  
**Witness**

*(print and sign)*

\_\_\_\_\_  
**Participant**

*(print and sign)*

The information collected on this form is collected by Alberta Health Services pursuant to s. 34 of the Health Information Act (HIA) of Alberta for the purpose of responding to your request. If you have questions about the collection and use of any information on this form by Alberta Health Services, contact the Disclosure Help Line at 1.855.312.2265.

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