INFORMED CONSENT FOR DISCLOSURE OF PERSONAL INFORMATION

Student Name: ____ Student ID ___________________

The University of Alberta collects and protects personal information under the authority of the Alberta *Freedom of Information and Protection of Privacy Act* for the purposes of operating the programs and services of the University.

I voluntarily authorize the University of Alberta to disclose the following information:

PERSONAL INFORMATION: my first and last name, immunization records, CPR, N95 fit testing and records containing the results of a police information check, and any accommodations I require in order to complete my placement

TO: placement sites and/or clinical educators affiliated with the agencies in whose facilities I may be placed. These agencies include but are not limited to: Alberta Health Services, Covenant Health, Capital Care, Carewest, Lifemark Health, CBI, other independent private practice clinics, school boards, and other agencies in Alberta, in other provinces in Canada, or international sites where I am placed.

FOR THE PURPOSE OF: requesting, facilitating and monitoring my clinical placements, and meeting the requirements of the placement provider.

THESE RECORDS WERE ORIGINALLY COLLECTED TO: facilitate enrollment and completion of my program of study, including clinical placements, at the University of Alberta.

This consent is effective immediately and shall remain valid for the duration of my program, or upon written request as described below.

I understand that I may request a copy of my signed consent form.

NOTE: Consents may be revoked at any time by so indicating in writing to the office seeking consent. This revocation will be limited to disclosure of the personal information after the date of revocation, and may affect my ability to complete an on-going placement.

Protection of Privacy – The personal information requested on this form is collected under the authority of Section 33 (c) of the *Alberta Freedom of Information and Protection of Privacy Act*. It will be used for the purpose of requesting, facilitating and monitoring my clinical placements, and meeting the requirements of the placement provider. Questions concerning the collection, use and disclosure of this information should be directed to Heather Bredy, Academic Coordinator of Clinical Education

This information will be retained and disposed in accordance with approved records retention and disposal schedules of the University.

Signature: ____ Date: _________________________