Mamalilikulla First Nation

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Confidential Information Release Form

I, _____, hereby authorize the release of confidential information pertaining to my medical records for the purpose of Patient Travel. This authorization is granted to Mamalilikulla First Nation Community Health Representative, Twyla Edmonds.

Please fill in the following details:

- **Name**: _____
- **Date of Birth**: _____
- **Phone Number**: _____
- **Personal Health Number (PHN)**: _____

I understand that the information released may include, but is not limited to, medical history, treatment records, diagnostic reports, and any other information deemed relevant for Patient Travel purposes.

I understand that I have the right to revoke this authorization at any time, except where information has already been disclosed based on this authorization.

I acknowledge that the release of this information is voluntary, and I release Mamalilikulla First Nation Community Health Representative Twyla Edmonds from any liability arising from the release and use of this information, except as may be required by law.

Signature: _____ Date: _____

Please retain a copy of this form for your records.

Twyla Edmonds
Community Health Representative
communications@mamalilikulla.ca
250-287-2955 ext. 7827