Consent to Participate in Family to Family Connections

If faxing send to 1-403-955-2444 attention:
Family and Youth Engagement Coordinator.
Please follow up with a phone call to the Coordinator to verify.

Consent to Participate

I, _____,
PRINTED NAME OF: ☐ supportive family volunteer ☐ requesting family member

consent to participate with Family to Family Connections. I acknowledge that I am aware this is a connection being made by Alberta Health Services for the purposes of family support. I understand that my role is not to provide or receive medical advice through this connection.

Consent to Disclose Health and Personal Information

I authorize Alberta Health Services to disclose my health or personal information with Family to Family Connections and with volunteers and staff for family matching within the service.

This information may be disclosed to:

- Family and Youth Engagement Coordinator, program manager or Alberta Health Services Volunteer Resources Coordinator
- Parents or family members participating in Family to Family Connections to facilitate a match with another family for the purposes of exchanging/receiving:
    - support;
    - information from a parents' point of view; and
    - linkages to Family & Community Resource Centre

I understand why I have been asked to disclose this information and am aware of the risks or benefits of consenting to disclose this information. I also understand that I may revoke this consent at any time.

Signed this _____ day of _____, 200 __ in _____, Province of Alberta.

_____ _____

SIGNATURE OF ☐ Supportive Family Volunteer ☐ Requesting Family SIGNATURE OF Witness

This consent expires one year from the date signed.

Release of Liability, Waiver of Claims, Assumption of Risks and Indemnity Agreement

All initial contacts between Supportive Family Volunteers and Requesting Family Members are to occur either by telephone, e-mail or on site at the Alberta Children's Hospital (ACH). Private ACH location arrangements can be facilitated by the Family to Family Connections Coordinator.

Alberta Health Services is not responsible for meetings or arrangements made between volunteers and families that occur outside Alberta Health Services. Alternate meeting arrangements and locations negotiated between a supportive family volunteer and a requesting family, other than those specified above, require the following declaration:

I am aware that participation in Family to Family Connections (the "Program") has inherent risks and I (on behalf of the participant, myself, my heirs, my next of kin) freely accept these risks. I waive all claims against Alberta Health Services (including its board members, directors, employees, agents, volunteers and independent contractors, as a result of my participation in the Program. I agree to indemnify Alberta Health Services from any and all liability for any damage to property of, or personal injury to any third party, resulting from my participation in the Program.

Signed this_____ day of _____, 200__in _____, Province of Alberta.

_____ _____

SIGNATURE OF ☐ Supportive Family Volunteer ☐ Requesting Family SIGNATURE OF Witness