



## CDTC Consent to Share Health Information

**To: Calgary Drug Treatment Court**  
**Suite 604, 620 7<sup>th</sup> Avenue SW**  
**Calgary, AB**  
**T2P 0Y8**  
**Phone: 403-476-4696**  
**Fax: 403-476-4701**

I \_\_\_\_\_ agree that my full Alberta Health  
(Applicant's name)  
information (programs and/or services) may be shared with the Calgary Drug Treatment Court,  
Treatment Team.

I \_\_\_\_\_ agree that my full Alberta Health  
(Applicant's name)  
Information (programs and/or services) provided by the Calgary Remand Centre may be shared with  
the Calgary Drug Treatment Court Treatment Team.

Full Signature: \_\_\_\_\_

Print Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_