CHU de Québec Université Laval

CQ12458

AUTHORIZATION TO RELEASE INFORMATION CONTAINED IN THE MEDICAL RECORD- CHU

I, the undersigned _____
Name and address

In my capacity of _____
User or person authorized

Authorize the establishment : CHU DE QUÉBEC – UNIVERSITÉ LAVAL
☐ HEJ ☐ HSS ☐ CHUL ☐ HSFA ☐ HDQ

To be send to: _____
To receive documents by email, please enter your email address here

The following information: _____

_____

Concerning the care or services received during the following period: _____

Such information in contained in the dossier of the above-identified user.

I authorize the CHU de Québec-Université Laval to send me the clinical documents to the email address mentioned above, which is my personal address. I understand that there are information security risks to using this method of communication and I accept these risks.

This authorization is valid for a period of _____ days following the date this document was signed.

_____ _____
Signatory: user or authorized person Date (yyyy/mm/dd)

_____ _____
Witness to the signature Date (yyyy/mm/dd)

N.B. : It must be assured that the persons signing this form are authorized to do so in accordance with the legislative texts in force. Where necessary, please indicate the capacity (guardian or holder of parental authority) in which the person is authorized to sign.