CHU de Québec Université Laval

DT9113

HSFA

AUTHORIZATION TO RELEASE INFORMATION CONTAINED IN THE MEDICAL RECORD

I, the undersigned, _____

Name and address

In my capacity of _____

User or person authorized

Authorize the establishment _____

To send the following information _____

_____

to: _____

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

_____

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

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

_____ Year Month Day

Signatory: user or authorized person Date

_____ Year Month Day

Witness to the signature Date

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.

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