



**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 is 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.

Signatory: user or authorized person

Year	Month	Day

Date

Witness to the signature

Year	Month	Day

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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