AUTHORIZATION TO RELEASE INFORMATION CONTAINED IN THE MEDICAL RECORD

DT9113

UNIVERSITÉ Concordia UNIVERSITY

Clinic file number:		Hospital file number:	
First and last name:			
Health insurance number:	Exp:	D.O.B.:	Sex:
Mother's first and last name:			
Father's name and last name:			
Phone number and extension:		Phone number and extension:	
Adress:			
Email:			

I, the undersigned, _____
Name and address

In my capacity of USER
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 60 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.***