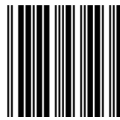




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 MCH  MGH  RVH  
 HNM  ITM  
 MNH  MCI

**AUTHORIZATION TO RELEASE INFORMATION**

Fax  Pick-up  Mail

Surname and given name(s) at birth:		Name used now:		Medical record number:
Surname & given name(s) of mother:		Surname & given name (s) of father:		
Present address of user:				
City		Prov. / Country	Postal Code:	
RAMQ#		Date of birth		
Telephone #		Alternate Telephone #		
Fax # <input type="checkbox"/> (Please forward original)		Pick up: (Name of person)	Phone number	

**I, THE UNDERSIGNED** \_\_\_\_\_

**IN MY CAPACITY OF** \_\_\_\_\_

**AUTHORIZE** \_\_\_\_\_

**TO RELEASE THE FOLLOWING INFORMATION:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**To:** \_\_\_\_\_

\_\_\_\_\_

**CONCERNING THE CARE OR SERVICES RECEIVED ON** \_\_\_\_\_

**THIS AUTHORIZATION IS VALID FOR A PERIOD OF 90 DAYS FOLLOWING THE DATE THIS DOCUMENT WAS SIGNED.**

\_\_\_\_\_  
 SIGNATURE OF PATIENT OR HIS LEGAL REPRESENTATIVE

\_\_\_\_\_  
 DATE (YYYY / MM / DD)

\_\_\_\_\_  
 WITNESS TO SIGNATURE

\_\_\_\_\_  
 DATE (YYYY / MM / DD)

THE ABOVE IS IN ACCORDANCE WITH AN ACT RESPECTING HEALTH SERVICES AND SOCIAL SERVICES, AN ACT RESPECTING ACCESS TO DOCUMENTS HELD BY PUBLIC BODIES AND THE PROTECTION OF PERSONAL INFORMATION (c. S-4.2) AND ANY OTHER PERTINENT ACTS. IT MUST BE ASSURED THAT THE PERSON SIGNING THIS FORM IS AUTHORIZED TO DO SO. PLEASE INDICATE THE CAPACITY IN WHICH THE PERSON IS AUTHORIZED TO SIGN. (CURATOR, HOLDER OF PARENTAL AUTHORITY)