INSTITUT UNIVERSITAIRE
DE CARDIOLOGIE
ET DE PNEUMOLOGIE
DE QUÉBEC

DT3634

AUTHORIZATION TO RELEASE INFORMATION CONTAINED IN THE MEDICAL RECORD

I, the undersigned, _____
Name and adress

In my capacity of _____
User or person authorized

Authorize the establishment Institut Universitaire de cardiologie et de pneumologie de Québec, 2725 chemin Sainte-Foy, Québec (Québec) G1V 4G5

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.

☐ Si la personne est incapable de signer, nous préciser la raison médicale et faire signer deux témoins.

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

_____
Signatory : user or authorized person

Date : Year Month Day

_____
Witness to the signature

Date : Year Month Day

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.

(Source MSSS - AH216)