AUTHORIZATION TO RELEASE INFORMATION CONTAINED IN THE MEDICAL RECORD

Surname and given name(s) at birth

Name now used

Present address of user

RAMQ No. | Birthdate: Year | Month | Day

File number: | Date of admission:

Surname and given name(s) of father | Surname and given name(s) of mother

Other names used previously

I, the undersigned, ______________________
Name and address

In my capacity of the patient
User or person authorized

Authorize the establishment ______________________

To send the following information previous fertility record

to: Centre de procréation assistée du CHU Sainte-Justine
Fax : 514 345-4914 *Please do not send by mail

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.

____
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.