



## 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  
Date

\_\_\_\_\_ Witness to the signature  
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.