Centre intégré de santé et de services sociaux de Laval
Québec

DT90600

AUTHORIZATION TO DISCLOSE MEDICAL AND PSYCHOSOCIAL INFORMATION

Personal information

File number : _____

First and last name: _____

Date of birth: _____

Health insurance number : _____

Please fill in all the information requested to avoid further delays.

I, undersigned :

First and last name: _____

Complete address : _____
Civic number, street name, city, postal code

Phone number : _____ Email : _____

In my capacity as :

☐ User ☐ Holding parental authority ☐ Representative of the user
(Please provide supporting documents)

Authorizes the establishment : CISSS de Laval – Medical Records Department

Site(s) : ☐ Hôpital de la Cité-de-la-Santé ☐ CLSC ☐ CHSLD : _____
☐ Centre de services ambulatoires de Laval ☐ Hôpital juif de réadaptation ☐ Centre jeunesse
☐ CRDI-TSA ☐ Other site : _____

☐ Others : _____
Name of establishment

_____
Civic number, street name, city, postal code

To send to : (We recommend transmission by e-mail.) If you have an appointment, please indicate the date: _____

☐ Myself Transmission mode : ☐ Email ☐ By post ☐ In person
☐ USB key ☐ Paper

☐ CISSS de Laval – Medical Records Department Email : acces.dossier.cissslav@ssss.gouv.qc.ca

☐ Other : _____

Complete address : _____
Civic number, street name, city, postal code

Phone number : _____ Email : _____

Transmission mode : ☐ Email ☐ Fax : _____ ☐ By post

The following information (care and services received): _____

_____

_____

For the following period (Month and/or year): _____

_____ _____
Signature of authorized person **Date** (YYYY-MM-DD)

** You must send us your completed form to the following e-mail address : **acces.dossier.cissslav@ssss.gouv.qc.ca** **

Act respecting health and social services information, section 34 « The person in charge of the protection of information must respond to a request promptly and not later than 30 days after the date the request is received. »