CONSENT TO ACCESS AND DISCLOSE INFORMATION RELATING TO MY HEALTH

I, the undersigned, ______________________________, residing and domiciled at __________ ____ grant and authorize ____, or one of her/his/its designated agents or delegates, to disclose and transmit to Dr. Pierre Brassard, or one of his designated agents or delegates, any information relating to my state of health, including but not limited to, any notes, any results, or any medical information necessary to provide me with health care, including steps to prepare for and follow-ups related to the surgery that I will undergo or in order to establish a treatment plan.

I also authorize Dr. Pierre Brassard and each of his designated agents or delegates to communicate and interact with healthcare system stakeholders regarding my state of health, where this is necessary to provide me with health care, including steps to prepare for my surgery and follow-ups related to my surgery, or in order to establish a treatment plan.

I confirm that I am of legal age and have the capacity to give this consent. I have carefully read this consent agreement before signing it and declare that I fully understand it.

In witness whereof I have signed the ____ day of the month of ____________________, 20___.

______________________________ ______________________________

[Print name] [Signature]

©This document and its content are the property of GRSMontréal