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Santé et Services sociaux Québec

DT9298

CONSENT FORM FOR THE SHARING AND RELEASE OF USER INFORMATION

CONSENT TO THE SHARING OF CERTAIN HEALTH INFORMATION ABOUT ME

I, the undersigned, _____, authorize the following people to access the information and documents contained in my medical record when they need this information and these documents to provide the health care and social services required by my state of health:

- Doctors and other health and social services professionals (nurses, social workers, and so on) at the _____ medical clinic, where my doctor practices

- Where appropriate, doctors and other health and social services professionals at other clinics in the same family medicine group (FMG) as my family doctor, i.e., the clinics listed on the santé mieux-être portal of Ministère de la Santé et des Services sociaux

This consent is valid for as long as I use the services of the abovementioned clinic. I understand that I am not required to provide consent, and I may withdraw my consent in writing, in full or in part, at any time. I acknowledge that I have read and understood the information on this form and have received any explanations I needed to understand it.

☐ Insured person ☐ Mother or father ☐ Guardian ☐ Mandatary ☐ Curator

Signature _____ Date ____ ____ ____
Year Month Day

User's name	File no.

CONSENT TO THE RELEASE OF CERTAIN HEALTH INFORMATION ABOUT ME

I, the undersigned, _____, understand that certain health and social services professionals who provide health or social services (nurses, social workers, and so on) at the family medical group (FMG) to which my family doctor belongs are employees of _____, a health and social services network facility (hereafter the "facility").

As such, the facility may occasionally request that my family doctor release certain information or documents consigned to my medical record by these professionals, to ensure service quality and coordination. The facility may also request certain information that other professionals, including my doctor, have consigned to my record, when such information is needed to assess service delivery quality by the individuals in question. The information this concerns is the following:

- Notes on treatment or consultations with other professionals or doctors
- Treatment plans
- FMG treatment summary, including the drug profile

I understand that all such requests by the facility will be accompanied by a signed authorization from the facility's director of professional services indicating the following:

- The identity of the professional concerned by the request
- The specific purpose of the request
- The other professionals involved and why their notes are required
- The scope of the requested information or documents (time period)
- A confidentiality agreement from the director of professional services providing that:
  1) The information released will be used only for the purposes indicated in my consent and
  2) The information released will be shared only on a need-to-know basis

I understand that I am free to provide or refuse consent, and that should I refuse I will still receive the care and/or services my state of health requires.

I hereby authorize my doctor to release any information the facility may request, according to the above terms and conditions.

My consent is valid for ten (10) years. However, I may totally or partially withdraw it at any time by informing my family doctor in writing.

I acknowledge that I have read the information on this form and have received any explanations I needed to understand it.

☐ Insured person ☐ Mother or father ☐ Guardian ☐ Mandatary ☐ Curator

Signature _____ Date ____ ____ ____
Year Month Day