COLLÈGE
DES MÉDECINS
DU QUÉBEC

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Consent Form
Communication of personal information to a third party

By the present, I authorize the Collège des médecins du Québec to disclose the following documents and information:

_____

(specify)

These documents must be transmitted to:

_____

Name of the person or organization

_____

Street

_____

City Province Postal Code

_____

Email address

To be sent by mail ☐ To be sent by email ☐

Address of the person who authorizes the transmission:

_____

Name Reference*
*(registration, resident or permit number)

_____

Phone number

_____

Street

_____

City Province Postal Code

_____

Email address

Signature (mandatory) **Date**

Please note that you will receive a copy of the documents sent to the third party.