COMPLEXE CHIRURGICAL
GRS MONTRÉAL

CONSENT TO SHARE INFORMATION WITH THE *PROGRAMME PROVINCIAL DE CHIRURGIE POUR LA DYSPHORIE DE GENRE*

Legal Name: _____ **Prefered Name:** _____

Date of birth: _____
(year/month/day)

TO BE COMPLETED BY THE PATIENT and returned to us as soon as possible

I, the undersigned, _____ residing and domiciled at

_____

grant and authorize the ***Programme provincial de chirurgie pour la dysphorie de genre*** or one of his designated agents or or delegates to disclose and transmit to or one of her/his/its 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 where of I have signed the _____ day of the month of _____ _____

_____ _____

PRINT NAME SIGNATURE