

INSTITUT  
DE CHIRURGIE  
**LAUNGANI**

**Medical Record Transfer Authorization Form**

I, the undersigned, \_\_\_\_\_ born on  
\_\_\_\_\_, holding the health insurance card number:  
\_\_\_\_\_, residing at the following address:  
\_\_\_\_\_, authorize the CMC  
clinic to transfer the entirety of my medical records to the Atelier du Corps – Institut de  
Chirurgie Laungani

**Recipient of the Transfer:**

Name of the receiving clinic: Atelier du Corps –Institut de Chirurgie Laungani  
Address: 200 Henri Bourassa East  
Phone: 438-258-8510  
Fax: 438-258-8758  
Email: admin@atelierducorps.ca

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**Consent:**

I understand that this authorization is required to allow the originating clinic to send my  
medical information. I consent to having my data sent via fax.  
I am informed that this authorization can be revoked at any time, but the withdrawal of  
this authorization will only apply to future data transfers and not to those made prior to  
the revocation.

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**Patient's Signature:** \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_