Centre intégré
de santé
et de services sociaux
de la Montérégie-Ouest
Québec

MOCLI60705A

Installation : ______________________________

Dossier : ____________________

Nom, prénom : ________________________________

Date de naissance : ________ ☐ F ☐ M
aaaa/mm/jj

NAM : ____________________ Exp. ____
aaaa/mm

Nom, prénom de la mère : ________________________

COMMUNICATION OF PERSONAL INFORMATION BY ELECTRONIC MESSAGING

This form does not replace the Autorisation à communiquer des renseignements contenus au dossier *(AH-216) form, but must be completed and attached to the authorization when email communication is requested by the applicant.*

I understand that the methods of communication considered secure and confidential by the CISSS de la Montérégie-Ouest are fax, regular mail, the user-portal of a DSN/DMÉ and Outlook encrypted email (between health network email addresses).

I acknowledge and understand that the CISSS de la Montérégie-Ouest cannot guarantee the security, integrity or confidentiality of communications sent via an electronic messaging system.

I understand and accept the following risks associated with the use of an electronic messaging system:

- Transmission of information to third parties;
- Inspection and retention of information by employers and online service providers;[1]
- Introduction of malware into a computer system;
- Redirection, interception, dissemination, storage and modification of information without the sender's, recipient's or user's knowledge or authorization;
- Despite the deletion of electronic messages, the presence of backup copies on a computer system;
- Disclosure of information pursuant to a reporting obligation or a court order.

I confirm that I was given the opportunity to ask all my questions and that I received satisfactory answers.

I, the undersigned, ____, in my capacity as ☐ user or ☐ legal representative
Block letters

☐ authorize or ☐ refuse, ☐ verbally or ☐ in person that the CISSS de la Montérégie-Ouest communicate by electronic messaging service at the following email adress: ____,

personal information ☐ concerning me or ☐ concerning the user identified above.

This authorization or refusal is valid for a period of ________ days from the date of signature or

☐ for the duration of the health or social services provided by: ____.
Worker/Service/Program

I understand that I may revoke this authorization or refusal at any time by filling out a new form.

Signature: ____ Date and time: ______________
User or legal representative — yyyy/mm/dd

OR Signature and title: ______________________________________ Date and time: ______________
Person obtaining verbal authorization or refusal — yyyy/mm/dd

Name in block letters: ____

[1] When this right is recognized by law