Santé
et Services sociaux
Québec

REFUSAL FORM OR MODIFICATION OF REFUSAL FORM

Québec Health Record (QHR)

IMPORTANT: To prevent identity theft and protect your personal information, **your request must be submitted along with a copy of a valid piece of signed photo ID** (health insurance card, driver's license, passport, etc.) **by mail**.
Failure to provide mandatory information may result in your request being delayed or turned down.

Section A: IDENTIFICATION

Fields with an asterisk (*) are mandatory.

* Last name		* First name	
* Date of birth YYYY/MM/DD	* Gender F M	* Home address (street, apartment)	
* City		* Province	* Postal code
* Phone number (daytime) ( ) -	Phone number (other) ( ) -	Email address	
* Mother's maiden name		* Mother's first name	
Father's last name		Father's first name	
* Identification: Health Insurance Card		* Number of Health Insurance Card	* Expiration Date YYYY/MM

Section B: IDENTIFICATION OF PARENT, TUTOR, CURATOR, OR MANDATARY

Complete the section if you are filing a request on behalf of the person named in Section A.
Attach a document authorizing communication (consent, power of attorney, or court decision) if necessary.

Last name		First name	
Address (street, apartment)			
City		Province	Postal code
Phone number (daytime) ( ) -	Relationship to the person	Email address	

Section C: TYPE OF REQUEST

☐ I am withdrawing my refusal. All my health information can now be released through the QHR.

I refuse to allow the release of my personal health information through the QHR
☐ indefinitely or until the following date: YYYY/MM/DD

Reasons for refusal (check all that apply):

- ☐ I do not see the benefit to the release of my personal health information.
- ☐ My refusal follows a discussion with my physician.
- ☐ My refusal follows a discussion with my family.
- ☐ I have a lack of confidence in data security and confidentiality.
- ☐ I can't limit access to certain health providers.
- ☐ I have had a bad experience.
- ☐ I don't want to give a reason.
- ☐ Other, specify:

Section D : SIGNATURE (MANDATORY)

Signature	* Date YYYY/MM/DD

Please mail the completed form along with a copy of a valid piece of signed photo ID to the following address:

Régie de l'assurance maladie du Québec
Service des relations avec la clientèle du Dossier santé
1125, Grande-Allée Ouest, Q059
Québec (Québec), G1S 1E7

To get help completing this form, please contact the Régie de l'assurance maladie du Québec at 418 646-4636 (Québec aera) or 514 864-3411 (Montréal area) or 1 800 561-9749 (elsewhere in Québec).

22-715-01WA