



## Consent to consult the Quebec Health Record (QHR)

I, the undersigned, \_\_\_\_\_, authorize the professionals of the Dental Clinic Roy to access my Quebec Health Record (QHR), specifically the section related to my list of medications.

The purpose of this consultation is to allow the treating professional to review my medication history in order to ensure my safety and to recommend a treatment appropriate to my health condition.

I understand that this consultation is confidential and that the information obtained will be used solely for the purpose of my dental care.

Date : \_\_\_ / \_\_\_ / \_\_\_ Patient's signature : \_\_\_\_\_

### Parent or guardian's signature, if patient is minor.

Name of parent/guardian : \_\_\_\_\_

Date : \_\_\_ / \_\_\_ / \_\_\_ Parent or guardian's signature: \_\_\_\_\_

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