



Indemnisation
des victimes
d'actes criminels

**AUTHORIZATION TO COMMUNICATE
with a health professional**

1. Fill out the form by entering the necessary information in the appropriate spaces.	▶	2. Send the completed document to the <i>Direction générale de l'IVAC</i>:		
		Online www.ivac.qc.ca	By mail 1199, rue De Bleury, C. P. 6056, succursale Centre-ville Montréal (Québec) H3C 4E1	By fax 1 888 927-0003

1. Information on the identity of the person who is a victim

Surname (as shown on the birth certificate)		First name	
IVAC File N° <input type="text"/>	Health Insurance Number (HIN) <input type="text"/>	Date of birth <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Address			Telephone
Number	Street	Apt.	Main
P.O. Box	City/Municipality		Other
Province/State	Country	Postal code	<input type="text"/> <input type="text"/> <input type="text"/>
Father	Surname	First name	
Mother	Surname	First name	

2. Authorization

I hereby authorize the *Direction générale de l'IVAC* to obtain or disclose any information deemed necessary to process my qualification application and financial assistance with a treating healthcare professional. This may include any information, administrative or medical documentation contained in my file or in the administrative file or any documentation obtained from an external resource by the *Direction générale de l'IVAC*. Information will be shared only when deemed necessary by the *Direction générale de l'IVAC*.

Unless I expressly withdraw my consent in writing, this authorization shall remain valid until my applications have been fully processed.

Signature