Suicide Prevention Centre of Montreal

CONSENT AND AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

Date of the request

I, the undersigned

_____ , _____
First name Last name

_____
Contact information (email and phone number)

_____ , _____ , _____
Postal address City Postal code

In my capacity as ◉ USER ○ PERSON IN CHARGE

authorize the facility Suicide Prevention Centre of Montreal

to forward to ☐ MYSELF ☐ THE INDIVIDUAL NAMED BELOW

_____ , _____
First name Last name

_____
E-mail

_____ , _____ , _____
Postal address City Postal code

The following information, in: ○ Paper, by mail ○ PDF, by e-mail

For care or services received relating to the following period :

_____

Contained in the file of the user identified above.

This authorization is valid for a period of _____ days following the date of signature of this document.

Signatory : _____
User or authorized person

This _____ day of the month_____ , 2025

Suicide prevention center of Montreal

2815 Sherbrooke East,
Montréal, QC, H2K 1H2

Administration : 514 723-3594
Crisis line : 1 866 APPELLE (277-3553)
E-mail : info@cpsmontreal.ca

cpsmontreal.ca