

CONSENT FORM FOR USE OF IMAGES

As part of your medical follow-up and the care that is or will be provided to you, the personnel involved in your healthcare may have access to pre-, per- and post-surgery photographs and video recordings. Access to and use of these images and video recordings by healthcare professionals are necessary to (i) provide you with care, (ii) follow-up of your medical file, and (iii) enable the training of the healthcare professionals of the Complexe chirurgical CMC, its affiliates, successors, and assignees (collectively the "CCCMC").

Furthermore, in order to participate in the advancement and development of our surgeries and the services surrounding them, as well as to increase public awareness of the various types of care provided by the CCCMC, the use and dissemination of pre- and post-surgery images and video recordings (the "Images") may be essential. Indeed, it is essential: (i) for the purposes of informing our patients and professionals about the surgeries offered and associated care, (ii) for the purposes of promoting to the public the care offered to our patients for educational purposes and to understand the implications of the care offered, (iii) for the purposes of sharing experiences and other similar legitimate purposes as determined by the CCCMC (collectively, the "Purposes").

Consent and Assignment of Rights

I authorize, voluntarily, the CCCMC and any person acting with the permission or under the authority of the CCCMC, to photograph, to record a video including sound or in any other manner; to use images of me, including pre-, per- and post-surgery images, as I have consented to in the last section of this form. The Images may reveal intimate parts of my body, such as genitalia, as well as distinctive characteristics such as tattoos, piercings, scars, etc.

I also grant permission to the CCCMC to copyright, produce, reproduce, publish, and display without restriction as to modification, in current or future CCCMC media, including the Before and After Images, for use by the CCCMC for the Purposes stated above.

I acknowledge that the CCCMC is and will be the sole owner of all rights to the Images. I acknowledge that the CCCMC has the right to use and exploit the Images at its sole discretion. I waive any and all rights I may have with regard to the Images.

Protection of Personal Information

Personal information will be kept for the period prescribed by law. Your medical file will be kept for the period stipulated in the Archives Act (chapter A-21.1)

INITIALS

I acknowledge and agree that the Images and related documents may contain personal, confidential and/or protected information about me or my health, including my name, image, surgical treatments administered to me, and my general health (collectively the "Personal Information"). I consent to the disclosure of my Personal Information to the CCCMC and to any person acting with their permission and authority, for the above-mentioned Purposes.

I further acknowledge and agree (i) that CCCMC will retain the Personal Information for as long as necessary for the Purposes, (ii) that the file containing the Personal Information will be kept primarily in an electronic database in Canada designed according to the highest security standards, and that it will be transmitted only to employees, contractors, to licensees or authorized representatives of CCCMC who require it for the Purposes, and (iii) that Personal Information may from time to time be disclosed to, stored or processed in jurisdictions other than Canada, and I acknowledge that while in such a jurisdiction, regulatory authorities may have access to it in accordance with the laws of such jurisdiction.

Portability

As of September 22, 2024, you will have the right to receive your personal information in a structured, commonly used and computer-readable format. Any such request must be made by e-mail at confidentialite@cmcmontreal.com. A form will then be sent to you to provide us with all relevant information related to your request.

Upon receipt of the duly completed form, we will make every effort to process your request, it being understood, however, that serious practical difficulties may limit our ability to do so.

Right of revocation

I understand that I may revoke this consent by writing to the CCMC Privacy Officer at the address below, except to the extent already disclosed by CCMC based on this document.

Complexe chirurgical CMC, 999 De Salaberry Street, Montréal, Québec H3L 1L2 or
confidentialite@complexechirurgicalecmc.com

Disclaimer

I release the CCCMC and any person acting with its permission or under its authority, including any licensee, from any and all liability for any claim of any nature whatsoever that may arise from the use or exploitation of the Images, including, any claim for defamation or for infringement of privacy rights, moral rights, publicity rights, confidentiality rights, copyright or any other rights.

This document constitutes the entire agreement between the parties. This document is governed by and shall be interpreted in accordance with the applicable laws of the Province of Quebec.

INITIALS

Consent

Please note that in all the cases mentioned below, we will never communicate your name and surname; the Images may, however, contain distinctive characteristics if applicable (i.e. one of your tattoo(s), piercing(s), scar(s)).

I consent to the optional distribution of the Images for the following purposes (please check the applicable boxes):

- ☐ For providing information to future CCCMC patients to help them understand the healthcare they will receive. To do so, the Images will be deposited on the CCCMC platform and will be accessible only to patients who are already seriously engaged in a process with the CCCMC and who have agreed to maintain the confidentiality of the Images they may become aware of. This platform is not accessible to the general public but only to future patients who are already engaged in a process with the CCCMC as described above.
- ☐ For healthcare education at conferences, webinars and the writing of scientific publications.
- ☐ On the GrS Montréal website and CCCMC social media to raise awareness, to inform, and to participate in the advancement of care provided by the CCCMC.
- ☐ *I refuse to consent to any optional distribution of the Images.*

I have read this document, certify that I am eighteen (18) years of age or older, and by signing below, I certify that I fully understand this document and agree to be bound by its contents.

First and last name of the patient: _____

Address: _____

Date: _____ Signature: _____

First and last name of the person with parental authority or the representative of the minor patient: _____

Signature : _____
(Parental authority or legal guardian)