MAHKOTA MEDICAL CENTRE 仁爱医院

REQUEST FOR AUTHORISATION TO RELEASE MEDICAL REPORT

Medical Record

I, hereby request MAHKOTA MEDICAL CENTRE or any of its Medical/Dental Practitioner to release the Medical Report of my *own / the patient identified herein* and I agree to pay for the charges associated with the release of the Medical Report, including without limitation to photocopies, supplies and postages:

My / the Patient's Name : _____

NRIC / Passport / Birth Certificate : _____

Patient No. : _____

My Relationship with the Patient (if applicable): _____

The purpose of the Medical Report to be released :

☐ Switching to another Medical/Dental Practitioner

☐ Seeking a Second Opinion

☐ Insurance Claim(s)

☐ Other Legitimate Purpose(s) (please specify) _____ .

I hereby declare and confirm that I made this request freely, voluntarily and without coercion and that the information given above is accurate and true to the best of my knowledge and belief, and that the Medical Report is required for the purpose stated above. I understand that I may be liable for prosecution for making false declaration. Further, I undertake full liability, responsibility, duty to indemnify and release MAHKOTA MEDICAL CENTRE SDN BHD, its employees, servants, agents or any Medical/Dental Practitioner of MAHKOTA MEDICAL CENTRE for any cost, legal proceeding, liability, loss or damage incurred or suffered by anyone arising out or in connection with the release of the Medical Report or any part thereof. I agree that the release of the Medical Report shall subject to official approval of MAHKOTA MEDICAL CENTRE.

Signature / Right Thumbprint :

OFFICE USE ONLY

Remarks :

_____

Name : _____

NRIC No. : _____

Address : _____

_____

_____

Contact No. : Home : _____ Mobile : _____

Date : _____

Witnessed By : _____