AUTHORIZATION TO RELEASE COPIES OF TAX INVOICE / GUARANTEE LETTER / MEDICAL CLAIMS FORMS

Admission & Registration

Patient Name:	Patient No.:
Passport / NRIC No.:	Date:
Tel No.:	Bill No.:

Authorization

I,____ (Passport / NRIC NO.______________________________)
*Patient / Legal Guardian of the above-mentioned patient, hereby authorize and instruct Mahkota Medical Medical Centre Sdn Bhd ("MMCSB") to release the below to Mr / Ms _______________________________
(Passport / NRIC No.______________________________).

☐ Copy of Summary Tax Invoice

☐ Copy of Detailed Tax Invoice

☐ Copy of Guarantee Letter together with its supporting documents

☐ Copy of Medical Claim Forms together with its supporting documents

I further agree to indemnify and keep MMCSB, its employees, Medical / Dental Practitioner of Mahkota Medical Centre indemnified against any cost, fees, expense, damage, claim, legal proceeding, demand, liability, loss, damage or action or whatever arising from releasing the above to the abovementioned recipient.

Signed By:

____

Name:
Passport /
NRIC No. :
Date:

For Office Use
Attended By:

____

Name:
Designation:
Employee No.
Date:

REQUEST FOR AUTHORISATION TO RELEASE MEDICAL REPORT

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 :

____

Name : ______________________

NRIC No. : ______________________

Address : ______________________

____

____

Contact No. : Home : ______________ Mobile : ______________

Date : ______________________

Witnessed By : ______________________

OFFICE USE ONLY

Remarks :

____

____

____

____

____

____