PENANG ADVENTIST HOSPITAL
465 BURMAH ROAD
10350 PENANG
MALAYSIA

AUTHORIZATION TO RELEASE MEDICAL REPORT

Patient NRIC Name _____

Hospital Number: _____ NRIC/Passport Number: _____

Date of Birth: _____ Sex: _____

I authorized Penang Adventist Hospital to release my medical records/reports to the following person / agent / company / insurance company.

To _____

Name

_____

Address

_____ Tel: _____

Fax: _____ e-mail: _____

Records requested:
- ☐ Discharge Documents
- ☐ X-ray Reports
- ☐ Medical Report
- ☐ Lab Reports
- ☐ Others _____

Period Covered: _____

SIGNATURE OF REQUESTOR / APPLICANT

Signed:_____ Date:_____
Patient/Parent/legal Representative/Spouse

Relationship to patient (if patient is not signing): _____ Witness: _____

Name:_____

Please indicate:
- ☐ Patient is a Minor
- ☐ Patient is unable to sign

Date: _____