PRINCE COURT
MEDICAL CENTRE

Patient's Name:		
MRN:		
Age:	Gender:	Room No:
Encounter No.:		Date:

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____ NRIC/Passport No. _____
(Name)

of _____
(Address)

hereby consent unequivocally for Prince Court Medical Centre Sdn Bhd to provide my personal data and sensitive personal data including but not limited to my medical information contained in the medical records of

*myself / my child / next-of-kin _____
(Name of Patient)

(relationship to patient) _____ MRN _____

Episode No. _____ Date of visit _____

to _____
(Name and NRIC/Passport *or* Name and Address of Organization)

Email: _____ Contact No: _____

and hereby unconditionally release Prince Court Medical Centre Sdn Bhd from all legal responsibility or liability that may arise from this consent.

☐ I disagree (Please specify reason: _____)

Patient's *Signature/Thumbprint

OR

*Parent's/Guardian's *Signature/Thumbprint
(For Minors / The Mentally Incapacitated Only)

Date : _____

Date : _____

If not signed by the patient, please specify reason: x _____

*Delete whichever is not applicable.

WITNESS

Signature : _____

Name : _____

NRIC : _____

Designation : _____

Date : _____

PTO

ACKNOWLEDGEMENT OF RECEIPT

Date : _____ Time : _____

The copy / copies of documents listed below :

- ☐ Discharge Summary
- ☐ Laboratory Results (Please specify) _____
- ☐ Imaging Results (Please specify) _____
- ☐ Medical Certificate
- ☐ Medical Report / Insurance Claim
- ☐ Others (Please specify) _____

have been released to _____ or
(Name of Patient)

_____ who is _____
(Name of Authorized Next-of-Kin) (Relationship to Patient)

to patient by :

Name of staff : _____

Date : _____

Time : _____