MAWAR Medical Centre

AUTHORIZATION TO RELEASE PATIENT MEDICAL REPORT

PATIENT'S PARTICULAR

Patient's Name	
NRIC / Passport No. / Birth Cert. No.	
Address	
Contact No.	
Date of Admission / Treatment Received	
Date of Discharge / Date of Certified Death	

AUTHORIZATION

☐ I, the above-named patient; or

☐ I, _____ (NRIC No. / Passport No. _____),
the next of kin of the above-named patient; or

☐ I, _____ (NRIC No. / Passport No. _____),
the legal representative of the above-named patient,

Do hereby expressly authorize Mawar Medical Centre to release my / the patient's medical report(s) as well as any / all information pertaining to diagnosis and / or treatment given and / or received at Mawar Medical Centre to :

_____

_____

_____

(Name and address of an individual, company or organization)

I further undertake to bear the cost and expenses incurred therein and release Mawar Medical Centre and its employees from any liabilities howsoever arising thereto.

Dated :

_____
Signature / Right Thumb Print of Patient

_____
Signature of Next Kin OR
Signature of legal representative
Relationship to Patient : _____

Note: This form is to be signed by the Parents / Guardian / Next-of-kin if the patient is under 18 years of age or is physically or mentally incompetent to consent for the release of information.