

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.

AUTHORIZATION TO COLLECT 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 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 , NRIC No. , Passport No. and address of the authorized collector)

I further undertake to 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.