ParkCity Medical Centre

CONSENT FOR RELEASE OF MEDICAL INFORMATION

For enquiries, please call +603-6279 3322 / 3321 or email to medicalreportpmc@asia1health.com
Note: Processing period is 14-28 working days.

MRN No.:	
Ref. No.:	

Date of Request:……

PATIENT'S INFORMATION

Name of Patient : _____ Contact No.: _____

NRIC/Passport No. : _____ Visit Date : _____
(Please provide copy of NRIC/Passport)

Attending Doctor : _____

REQUESTOR/AUTHORIZED PERSON'S INFORMATION

Name : _____ Contact No. : _____

NRIC/Passport No. : _____ Email Address : _____

Relationship to Patient : _____ Signature : _____

I hereby confirm above information provided is the authorized person by the patient to apply for and receive the patient's medical report or medical information as per consent form or attached letter.

TYPE OF REPORT

- ☐ Medical Report/Lawyer
- ☐ Endorsement/Investigations/Discharge Summary
- ☐ PERKESO/SOCSO/KWSP/EPF
- ☐ Claim Form/Questionnaire: _____
- ☐ Others:_____

METHOD OF COLLECTION

- ☐ On-site at Health Information Management, Level 3
- ☐ Email: _____
- ☐ Courier Services – ***fee is applicable***

(please provide address): _____

_____

***Important Note for the Requestor:**
1. If the requestor is third-party personnel, a **consent letter** signed by the patient must be submitted together with this form. **This form is applicable as a consent letter for self-request.**
2. A copy of patient's NRIC/Passport is required for verification purposes (for deceased patient, the death certificate is required along with a copy of NRIC/Passport of next of kin).

I am fully aware and clear of the Notice under the Personal Data Protection Act 2010 and consent to the processing of my / patient's personal data and sensitive personal data in accordance with the CMC Privacy and Personal Data Protection Policy which is available at https://parkcitymedicalcentre.com/privacy-and-pdpa-policy. I further release the attending doctor(s) of ParkCity Medical Centre and its officers from any legal responsibility or liability that may arise from the act hereby authorized & undertake to settle all costs and expenses incurred therein. By signing below, I hereby confirm that the information provided is accurate, correct, complete and that the documents submitted along with this application form are genuine. I hereby authorize ParkCity Medical Centre to disclose and release the patient's medical report as well as any/all information pertaining to diagnosis and/or treatment given and/or received at ParkCity Medical Centre. I am aware the uncollected hardcopy reports will be disposed within three (3) months from the application date.

Patient / Next-of-kin Signature: _____ Date: _____

Name: _____

FOR OFFICE USE ONLY

- ☐ Approved for release
- ☐ Rejected (Justification): _____

Report Fee: _____

Doctor's Signature: _____

Due Date for Completion: _____