NORTHERN
HEART HOSPITAL PENANG

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APPLICATION & CONSENT FOR RELEASE OF MEDICAL INFORMATION

1. This form must be fully completed and signed by the patient or other relevant requestor.
2. If patient is below 18 years old, the form should be signed by patient's parent or legal guardian. All names must be in full name as per NRIC/passport.
3. Patient to enclose a photocopy of own NRIC (front and back view) if submitting via mail or email
4. This application is subject to Northern Heart Hospital Penang's approval.

Name: _____ NRIC / Passport No: _____ MRN: _____

Address: _____

Contact No.: _____ Admission Date: _____ Outpatient Visit Date: _____

AUTHORIZED PARTICULARS

I, as name above hereby authorise NORTHERN HEART HOSPITAL PENANG to furnish and release requested medical information below to:

Name of Representative: _____ NRIC / Passport no: _____

Relationship: _____ Contact no.: _____

DELIVERY METHOD (☐ Choose one option ONLY)

☐ Self-Collections
☐ Email (The original hardcopy will not be provided thereafter). Email Address:
_____

☐ Local Mail (fees apply). Mailing Address:
_____

TYPE OF REPORT (☐ Tick accordingly)

☐ Insurance Claim
☐ EPF
☐ SOCSO
☐ Written Medical Report
☐ Discharge Summary
☐ Other *(please specify)*:_____
☐ Investigation Report (*please specify*:_____

DECLARATION & AUTHORISATION LETTER TO RELEASE PATIENT INFORMATION FOR MEDICAL REPORT(S)

I hereby declare and confirm that the above consent and that the information given is accurate and true to the best of my knowledge, and that the requisite information is required for the sole purpose stated above. I understand that I may be liable for prosecution for making any false declaration herein. Further, I also agree to cover all costs and expenses related to the and shall not hold Northern Heart Hospital Penang's or any of its employees, servants or agents responsible in any way whatsoever for the release of the said medical information to any party by me in the event of any loss or damage arising directly or indirectly, as a result of or in connection with the release of such confidential information. By reason of the aforesaid, I undertake full responsibility and liability arising from the release of the requisite Information.

_____	_____	_____
Signature of Patient & Date	Signature of Representative upon collection (if applicable) &Date	Relationship to Patient