Gleneagles Hospital
PENANG

Affix patient's label here

Application Form for Release of Medical Information

Patient's Particulars:

Name: _____ NRIC/Passport No.: _____

Contact No.: _____ Organization Name: _____

Admission/Visit Dates: _____ Attending Doctors: _____

Types of Reports:

☐ General Medical Report
(Eg: Critical Illness Report, Death claim, Hypertension Report, Total Permanent Disability Report)

☐ Personal Medical Report

☐ Claim Form [Daycare/ Inpatient / Outpatient / Personal Accident]

☐ Investigation Report (Lab result, X-ray, etc.)

☐ Perkeso/Socso

☐ Employees Provident Fund (EPF) Report

☐ Legal / Specialist Medical report

☐ Discharge summary

☐ Others (Please State: _____)

I acknowledge and agree that charges may apply for this request, and I understand that it may take up to 30 days for processing and preparation. Furthermore, I will settle both the report fee and any outstanding amount owed to the hospital on the same day for the request to be processed.

Preferred Mode of Collection:

For collection, I authorize the following person and he / she shall provide the detail of patient's NRIC or Passport Number and/or authorized person's NRIC or Passport Number for verification purposes and that the medical report cannot be released if I am unable to do so. Additional charges may apply for mailing.

☐ Self-collect ☐ Email _____ ☐ Mailing (Address)_____

☐ Collected by Authorized Person (As detailed in the box below)

Name: _____ NRIC/Passport No.: _____

Contact No.: _____ Relationship to patient: _____

I confirm that all personal data submitted to the Hospital is complete, true and correct. Failure on my part to do so may result in the Hospital's inability to provide me or cause a delay with the services I have requested. I acknowledge that this consent form shall serve as an authorization for the release of the private medical information to the authorized person(s). I agree that a photocopy of this form shall be deemed 'valid' as the original consent.

In line with the "PERSONAL DATA PROTECTION ACT 2010", this consent indicates that the requestor has consented for the disclosure of his / her personal data and will not hold the doctor concerned, the hospital management and its staff responsible for the release of their personal data. The consent should be signed by the patient who has full mental faculty or the patient's legal guardian.

I have read, understand and consent to IHH MY Personal Data Protection Notice, accessible at https://www.ihhhealthcare.com/my/data-protection-notice.

_____
Signature of Patient / Patient's Next of Kin (NOK)
(NOK applies if Patient is medically, mentally, physically or legally incompetent)

Name:

Relationship with Patient (for NOK):

NRIC/Passport No:

Date:

_____
Signature of Witness

Name:

NRIC/Passport No.:

Date:

Declaration of Translation:

Translator Name:	**NRIC/Passport No.:**
Translated to the abovenamed patient in _____(Please specify language / dialect) by the undersigned who confirmed that the patient understood and acknowledged the contents of this application form.	Signature & Date:

For office use only:	Processed by / Signature & Date:
Episode number (Visit): _____ Report No.: _____	
Episode number (Payment): _____ Request Date: _____	