Hospital Pakar Damansara 2

himsdsh2@kpjdamansara2.com

Ref No: _____

Date Completed: _____

Date Informed: _____

Fee: _____

For office use only.

Note: Minimum processing period is within 14 working days.

APPLICATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT'S INFORMATION

Name of patient : _____ MRN/Visit Date : _____

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

Attending Doctor/Specialty : _____ Date of Request: _____

REQUESTOR'S INFORMATION

Name : _____

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

Email : _____

Relationship to patient: ☐ Self ☐ Next-of kin (please specify): _____
☐ Insurance Agent ☐ Others (please specify): _____

REPORT TYPE (Please tick ✓)

☐ MO Medical Report (Free-text)
☐ Specialist Medical Report (Free Text)
☐ Specialist Medical Report for Lawyer (Simple)
☐ Specialist Medical Report for Lawyer (Complex)
☐ Claim Form by MO _____(Please state name of insurance company / agency)
☐ Claim Form by Specialist _____(Please state name of insurance company / agency)
☐ Laboratory Results
☐ Discharge Summary
☐ Radiology Results
☐ KWSP/EPF PERKESO/SOCSO
☐ Vaccination Records
☐ Amendment of Report (please specify reason) : _____
☐ Others (please specify): _____

COLLECTION OF REPORT

☐ On-site collection at Health Information Management Service Room, Level 6 , Hospital Pakar Damansara 2.
☐ Postal/Courier Services (please provide postal address) _____
_____
☐ Email: _____

Hospital Pakar Damansara 2

***Important Note for the Requestor:**

1. If requestor is third-party personnel, the Consent for Release of Medical Information and authorization later signed by the patient must be submitted together with this application form.
2. A copy of requestor's NRIC/Passport and patient's NRIC/Passport are required for verification purposes.
3. There shall be an administrative fee of RM20
4. If you are sending a representative to collect the report on your behalf, a Hospital Pakar Damansara 2 authorization letter signed by patient is required.
5. Any request of medical information for a deceased patient, a **Grant of Probate** or **Letter of Administration** is compulsory.
6. Only applications with completed documentations will be processed.

DECLARATION

I, the above-named patient / next of kin of the above-named patient / insurance agent of the above named-patient legal representative of the above-named patient* declare that the information given above is true and correct. I consent to KPJ Healthcare Berhad Personal Data Protection Notice and authorize Hospital Pakar Damansara 2, [Company No. 334166-V] to release the medical report (s) and /or information relating to the diagnosis and/or treatment given at Hospital Pakar Damansara 2 to the requestor stated above through the preferred method mentioned.

By signing below, I understand and agreed that the hospital has advised me to collect the medical report (s) personally but I choose to have the medical report released / sent by the method I have selected. I shall not hold Hospital Pakar Damansara 2 and its employees responsible for any losses, damages or any other type of losses resulting from my choice of release / delivery of the medical report (s) and shall further undertake to pay all costs and expenses incurred therein.

Agreed and accepted by Patient / Next of Kin /Insurance Agent / Legal Representative*	**Signature**	**Name in full**	**NRIC/ Passport No**
Witnessed by			
Date:			

* Delete as appropriate

****Note**: This form is to be signed by the patient. If the patient is below 18 years of age, the form should be signed by the patient's parent or legal guardian. If the patient is mentally or physically disabled, the spouse or parent or next of kin may sign the form.

If the patient is deceased, a copy of the patient's death certificate and written consent from the patient's next of kin / a copy of Letter of Administration / Grant of Probate, whichever applicable.

FOR OFFICE USE ONLY

DOCTOR'S AUTHORIZATION

☐ Approved for release **REPORT FEES: RM** _____

☐ Not approved for release

Justification: _____

_____

_____

Doctor's Signature: _____

FOR AMENDMENT OF REPORT (*if applicable*)

VERIFIED BY :

Clinical Head Name: _____

Signature : _____

Prepared by HIMS staff:

Name: _____

Date: _____

Released by HIMS staff:

Name: _____

Date: _____

☐ Email

☐ Post _____(courier tracking number)

COLLECTION OF REPORT:

Authorization Letter:

☐ Yes ☐ Not applicable

Collected by (name):

_____

Signature:

_____

NRIC/Passport No.:

_____

Date: Time:

_____ _____

Hospital Pakar Damansara 2

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____ NRIC/Passport No. _____
(Patient / Next-Of-Kin)

as a _____, hereby consent unequivocally for
*(Relationship to Patient - *Please remark as dash '__ ' for self-apply)*

Hospital Pakar Damansara 2 to provide my personal data and sensitive personal data including but not limited to my medical information contained in the medical records of *** myself / my child / next-of-kin** _____ **MRN** _____
For apply on behalf only - Name of Patient

to _____
Name and NRIC / Passport No. OR Name and address of organization

and hereby unconditionally release Hospital Pakar Damansara 2 from all legal responsibility or liability that may arise from this consent.

☐ I disagree (Please specify reason): _____

Patient's or Next- Of- Kin Signature / Thumbprint **OR** Parent's/Guardian's Signature / Thumbprint
(For Minors/ The Mentally Incapacitated Only)

Email :

Contact Number :

Date :

If not signed by the patient, please specify reason: _____