PANTAI JERUDONG
SPECIALIST CENTRE

Req no.:

APPLICATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION

Patient name: _____

Date of Birth: _____ NRIC no. : _____ PRN no. : _____

APPLICATION INFORMATION

Application is made for or on behalf of*:
(*please delete which is not applicable)

1. Self (own application) ; or
2. Relation: _____ (please state relationship to patient)

Name: _____

NRIC no. : _____ Contact no. : _____ Email: _____

Please tick (✓) all appropriate boxes

TYPE OF REPORT

- ☐ Medical Report
- ☐ Discharge Summary
- ☐ Photocopies of Medical Records
- ☐ Insurance Report
- ☐ Other(s) please specify: _____

Attending doctor

_____

(Please stick PRN sticker here)

Please state the ***purpose*** for requesting file/ information:

_____

COLLECTION OF REPORT:

☐ Self-Pickup ☐ Email (As Above) ☐ Postal _____

NOTE:
1. If an application is made on behalf of another person, this Form must be accompanied and submitted together with Authorisation for Release of Medical Information signed by the patient.
2. Applicant's Identity Card and Patient's Identity Card must be provided for verification.
3. Fees and charges may be imposed according to PJSC Charge Slip.

- The Applicant is applying for the release of medical information of the Patient.
- Requested information may consist of Human Immunodeficiency Virus ("HIV") infection, Acquired Immunodeficiency Syndrome ("AIDS") , treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.
- The Applicant understands that this request is valid for 6 months but it may be revoked at anytime before PJSC had acted on it. To be effective the revocation of the application must be in WRITING and received by the Medical Records Department of PJSC.
- The Applicant understand that the information may no longer be protected once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.
- The Applicant hereby unconditionally release PJSC from all legal responsibilities or liability that may arise from this form.
- The Applicant treatment or payment for The Applicant treatment cannot be conditioned on the signing of this authorization.
- The Applicant hereby confirm that the information provided above are accurate, correct and complete and that the documents submitted along with this application are genuine.

_____ _____

SIGNATURE DATE & TIME

FOR OFFICE USE ONLY
Doctor's Authorization

☐ Approved for release
☐ NOT approved for release (Please state justification below) :

_____

MRD STAFF

PREPARED BY Name & Date: _____

RELEASED BY Name & Date: _____

COLLECTION OF REPORT

Authorization Letter: ☐ YES ☐ N/A

Collected by (name) : _____

NRIC/Passport no. : _____

Date & Time : _____