PANTAI JERUDONG
SPECIALIST CENTRE

Req no.:

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Release of Medical Information

I _____ NRIC No. _____
(name)

of _____
(address)

hereby consent for Pantai Jerudong Specialist Centre ("PJSC") to the release and disclose to the party stated below privileged personal information including medical information of the following person:

1. (Name) _____ (PRN No.) _____

The information relates to me/my spouse/my child/my ward*
*(*please delete whichever is not applicable)*

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

_____

RELEASE RECORDS FROM:
Pantai Jerudong Specialist Centre
Jerudong BG3122 Brunei Darussalam

+673 261 1333 ext. 2189
+673 737 1763
roi.info@pjscbrunei.com
www.pjscbrunei.com

RELEASE RECORDS TO:

Name / Organization:

_____

Address with Post Code:

_____

Phone no. : _____ Email: _____

Note for the requestor:
We may apply fees or charges per PJSC Charge Slip, but we will notify you of any applicable fees before we process your request.

- I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/ facility/entity.
- I understand that the records released may include information relating to Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.
- I understand that this request is valid for SIX (6) months unless I notify PJSC otherwise. I may revoke this request in writing at any time except to the extent that PJSC has already relied on this request. I may revoke it by mailing or faxing a written notice to the Medical Records Department, PJSC, stating my intent to revoke this request.
- I 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.
- I unconditionally release PJSC from any responsibility and liability resulting or arising from the disclosure of the privileged information.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
- I hereby confirm that the information provided above are accurate, correct and complete and that the documents submitted along with this application are genuine.

_____
Patient's Signature

_____
Parent's / Guardian's Signature

_____
Date & Time

_____
Date & Time