MRN:

SALAM SENAWANG
SPECIALIST HOSPITAL

MEDICAL REPORT RELEASE AUTHORIZATION LETTER

1. PATIENT INFORMATION

Name: .....

NRIC/Passport No.: .....

Address: .....

.....

Phone Number: .....

Email Address: .....

CONSENT & AUTHORIZATION

I, the undersigned, hereby authorize and give my full consent to SALAM Senawang Specialist Hospital to prepare, process, and release my medical report and/or related medical records.

PURPOSE OF REQUEST:

☐ Insurance Claim
☐ Legal Matter
☐ Employment
☐ Personal Reference
☐ Other: .....

2. AUTHORIZED REPRESENTATIVE / NEXT OF KIN

Name/Organization: .....

Relationship to Patient (if applicable): .....

Address: .....

.....

Phone Number: .....

Email Address: .....

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3. AUTHORIZATION

1. Once disclosed to a third party, the hospital will no longer have full control over how the information is stored, used, or further shared.
2. Processing fees may be charged for the preparation of the medical report and/or copy of medical record.
3. I was advised to collect my medical report in person, but I choose another delivery method and accept all risks, including possible loss or unauthorized access to my confidential information.
4. The preparation process may take time according to hospital procedures.
5. The information released will be used only for the purpose stated above.
6. Only applications with completed documentations will be processed.

I declare that the information provided is true and correct.

Signature of Patient: .....

Name: .....

Date: .....

*NOTE: This form is to be signed by the Parents/Guardian/Next-of-kin of the patient if the patient a Minor (under 18 years of age), or has a mental incapacity to consent for the release of information, or is deceased.