Gleneagles Hospital
PENANG

Application Form for Release of Medical Information

Patient's Particulars:

Name: _____ NRIC/Passport No.: _____

Contact No.: _____ Organisation/Insurance Company.: _____

Admission/Visit Dates: _____ Attending Doctors: _____

Types of Reports:

☐ Medical Report (Please State: _____)

☐ Claim Form [Inpatient / Outpatient] (Please State: _____)

☐ Investigation Report (Lab result, X-ray, etc.) ☐ Medical Certificate / Discharge summary

☐ Others (Please State: _____)

I am aware and accept the charges for this request may apply and to allow up to 30 days for processing and preparation of the above mentioned request.

Preferred Mode of Collection:

For collection, I authorise the following person and he / she shall provide the detail of patient's NRIC and/or authorised person's NRIC 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 (Please State: _____)

☐ Mailing (Address: _____)

☐ Collected by Authorised 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 authorisation for the release of the private medical information to the authorised 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.

By consenting, I also agree to Parkway Pantai Group and their representatives and/or agents collecting, using and disclosing my/patient personal data to provide me with medical treatment and other reasonably related purposes. Such purposes are set out in the Data Privacy Policy, accessible at http://www.gleneagles.com.my/legal/privacy-policy or available on request.

_____	_____
Signature of Patient/ Parent / Legal Guardian	Signature of Witness
Name:	Name:
NRIC/Passport No.:	NRIC/Passport No.:
Date:	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 : _____	