

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ HN: _____

I (Mr./ Mrs./ MS) _____ Age _____ Yrs.

As ☐ Patient myself

☐ Representative of aforementioned patient's _____ (State the relationship)

**The patient authority means the rightful representative of a minor (Not over 20 years old or under the age of majority by registered marriage).*

The legal guardian of the incompetent by court order, legal guardian of the person who is incapacitated by court order

I authorize Samitivej Hospital to use or disclose the above named patient's health information as described below.

☐ Summary of Hospitalization ☐ Summary of Outpatient / Clinic visit note ☐ Medical Certificate

☐ Immunization Record ☐ Investigation results (Please Specify: Pathology, Lab, X-ray, EKG, etc.)

☐ Radiology Images : description _____

(This request will be forwarded to the Imaging Center for processing. If you have any questions, please call 027118300-1)

☐ Other (Please Specify): _____

Date or duration of treatment / Service: _____

(For example :dd/mm/yy 01/01/2005 or duration : Jan-July 2006 . If date/duration are not provided,The last 5 years of recent Medical record will be released)

This information for which I am authorizing disclosure will be used for the following purpose:

☐ Continuing medical treatment at _____ (Hospital Name)

☐ Insurance purpose: _____ (Insurance Company Name)

☐ Compensation claim from: _____ (Government, State Enterprise, Company)

☐ Pre-employment Health check-up ☐ Medical profile to be kept at my current company

☐ Legal purpose

☐ Other, (Please Specify) : _____

Preferred method of delivery

☐ Self pick-up at hospital ☐ Delivery to the authorized person : Name _____

☐ Via E-mail address : _____ Contact Phone Number: _____

☐ Via Postal address : _____

Remarks : *Release of HIV-related information, Substance abuse, Mental Health Record, Genetic Testing cannot be sent by fax or e mail.*

I acknowledge and understand that all medical information is confidential and secured by The Samitivej Sukhumvit Hospital

The information will not be released unless specifically authorized by the patient with evidence of written consent.

I understand that my medical records may include of HIV-related information, Substance abuse, Mental Health Record, Genetic Testing

I hereby take full responsibility for all consequences that may occur from the disclosure of the above medical information.

I also understand that I will be charged for additional copies and mailing fees (If applicable)

(_____)

Signature of Patient / Legal Representative

(_____)

Signature of Authorized Person receiving Health information

Request Date: _____

Released Date: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

患者名

原本に英語で記入してください

Patient Name:

生年月日

原本に英語で記入

Date of Birth:

してください

診察券番号

原本に英語で記入

HN:

してください

I (Mr. / Mrs. / MS) _____ Age _____ Yrs.

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☐ Other (Please _____)

Date or duration of t _____

(For example :dd/mm/yy 0

This information fo _____

☐ Continuing m _____

☐ Insurance pur _____

☐ Compensation _____

☐ Pre-employm _____

☐ Legal purpose _____

☐ Other, (Please _____)

赤線で囲んでいる箇所は、お申し込みいただいた内容をもとに当院スタッフが記載いたします。

黄色マーカー部分（患者名、生年月日、診察券番号、署名）のみ、原本に英語で記載してください。

Preferred method of delivery

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☐ Via Postal address : _____

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原本に署名してください

(_____)

Signature of Patient / Legal Representative

患者・代理人の署名

原本に署名してください

(_____)

Signature of Authorized Person receiving Health information

受取人の署名

Request Date: _____

Released Date: _____