

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:	Date of Birth:	HN:
I ( Mr./ Mrs./ MS )		AgeYrs.
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 major.	ity 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 n	amed patient's health information as de	scribed below.
☐ Summary of Hospitalization ☐ Summary of	f Outpatient / Clinic visit note	Medical Certificate
☐ Immunization Record ☐ Investigation	results (Please Specify: Pathology, Lal	b, X-ray, EKG, etc.)
☐ Radiology Images : description		
(This request will be forwarded to the Imaging Center fo.	r processing. If you have any questions, please co	ıll 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/du	ration are not provided, The last 5 years of recen.	t Medical record will be relea.
This information for which I am authorizing disclosure v	vill be used for the following purpose:	:
☐ Continuing medical treatment at		( Hospital Name
☐ Insurance purpose:		(Insurance Company Na
Compensation claim from:	(Governmen	t,State Enterprise, Comp
☐ Pre-employment Health check-up ☐ Medic	cal profile to be kept at my current com	pany
☐ Legal purpose		
Other, (Please Specify):		
Preferred method of delivery		
☐ Self pick-up at hospital ☐ Delivery to the author	prized person :Name	
☐ Via E-mail address :	<del>-</del>	
☐ Via Postal address :		
Remarks : Release of HIV-related information, Substance abuse, Mental a	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 Samit	ivai Sukhumvit Hoenital
The information will not be released unless specifically autho	·	_
I understand that my medical records may include of HIV-re	fated information, Substance abuse, we	antai Heann Record
,GeneticTesting	and the land of the land	
I hereby take full responsibility for all consequences that may		medical information.
I also understand that I will be charged for additional copies a	and mailing fees ( If applicable )	
- <del></del>	<del></del>	
Signature of Potiont / Logal Popresentative	Signature of Authorized Person re	
Signature of Patient / Legal Representative	Signature of Authorized Person re	cerving nearth informat
Request Date:	Released Date:	
NAUGOLIJAE.	NEIGANGU DAIC.	



## 記入説明用資料 記入は1枚目にしてください

Released Date:

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

患者名 Patient Name:	原本に英語で記入してください	生年月日 Date of Birth:	原本に英語で記入 してください	診察券番号 HN:	原本に英語で記入 してください
I (Mr./Mrs./MS)		////////	/////////	////////	AgeYrs.
As Pati Rep *The patient a  The legal guardian of I authorize Samit Summary of Immunizat Radiology  The Other (Plead Date or duration of For example :dd/mm/) This information Insurance	ent myself presentative of aforementioned pation of the incompetent by court order, legal guarative of Hospitalization	of a minor (Not over dian of the person w above named pa nmary of Outpat stigation results Center for processi る箇所は、	ho is incapacitated by contient's health informient / Clinic visit note (Please Specify: Panage of Panag	Sta e age of majority by re urt order nation as described te	te the relationship)  gistered marriage).  d below.  al Certificate  ny, EKG, etc.)
Compensa Pre-emplo Legal purp Other, (Plea	ym 番号、署名)のみ				nterprise, Company
Preferred method Self pick-u Via E-mail Via Postal Remarks: Release of	up at hospital		ntact Phone Number:		e maîl.
I acknowledge and The information w I understand that n GeneticTesting I hereby take full r	I understand that all medical informable in the released unless specificating medical records may include of responsibility for all consequences that I will be charged for additional	nation is confide  Ily authorized by  HIV-related in  that may occur f	ntial and secured by the patient with evi formation, Substand rom the disclosure o	The Samitivej Suidence of written of the abuse, Mental F	khumvit Hospital consent. Jealth Record
Signature of P	xに署名してください Patient / Legal Representative	<mark>Si</mark> į	gnature of Authorize		
患者・代	<mark>、理人の署名</mark>		<mark>受取人。</mark>	の <mark>署名</mark>	

Request Date: \_\_\_\_