สมิติเวช สุขุมวิท
SAMITIVEJ SUKHUMVIT

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 ,GeneticTesting

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: _____

สมิติเวช สุขุมวิท
SAMITIVEJ SUKHUMVIT

記入例
記入は１枚目（原本）にしてください

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: 原本に記入してください

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).*

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❒ 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 _____

Date or duration of t _____

(For example :dd/mm/yy 0 ent Medical record will be released)

This information fo se:

❒ Continuing m _____ (Hospital Name)

❒ Insurance pur _____ (Insurance Company Name)

❒ Compensatio nt,State Enterprise, Company)

❒ Pre-employm mpany

❒ Legal purpos(

❒ Other, (Please Specify) : _____

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。
黄色マーカー部分のみ（患者名、生年月日、診察券番号、署名(パスポートと同じもの)）を、原本に英語で記載してください。

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.*

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原本に　パスポートと同じ署名をしてください　　原本にパスポートと同じ署名をしてください

(_____)　　(_____)

Signature of Patient / Legal Representative
患者・代理人の署名(パスポートと同じもの)

Signature of Authorized Person receiving Health information
受取人の署名（パスポートと同じもの）

Request Date: _____　　Released Date: _____