

**CONSENT AND AUTHORIZATION FORM
TO RELEASE PATIENT INFORMATION**

PATIENT DETAILS:

Full Name :

NRIC Number :

Phone Number : Date :

PARENTS / LEGAL GUARDIANS:

Full Name :

NRIC Number :

Phone Number : Date :

Relationship To Patient :

Hereby give consent to AVISENA Healthcare to release information for the purpose of **INSURANCE / MEDICAL REPORTS / SOCSO / KWSP / MEDICAL LEAVE CERTIFICATE (MC) / IMMUNIZATION REPORT / DISCHARGE SUMMARY / INVESTIGATION REPORT** or(please specify) for application purposes and any information related to the diagnosis and / or treatment provided and received at AVISENA Healthcare **(Please tick either one);**

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to my representative as per detail below;

REPRESENTATIVE DETAIL:

Full Name :

NRIC Number :

Relationship :

Phone Number : Date:

(Signature of Patient/ Parent/ Legal Guardian)

(Signature of Representatives)

*NOTE: This form is to be signed by the Parents/Legal Guardians/Representative of the patient if the patient is under 18 years old, or has a mental incapacity to consent for the release of information, or is deceased.