AVISENA WOMEN'S & CHILDREN'S SPECIALIST HOSPITAL

AVISENA HEALTHCARE

AVISENA SPECIALIST HOSPITAL

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);**

☐ **AVISENA SPECIALIST HOSPITAL**

☐ **AVISENA WOMEN'S & CHILDREN'S SPECIALIST HOSPITAL**

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.