BANGKOK HOSPITAL
PHUKET

Name……………………………..…..............…………

HN…………………AN………….……..DOB…………

Age…………Gender………………Visit………………

Release of Medical Information

Date:………………..………………..….

I, Mr./Mrs./Miss:……………………………………………………………………….DOB:…………….……Age:……..…Years, H.N………………………….……….

Identification Card/Passport/ Driving License No:……………….………..… Issued at: …………………………….. Expiration date:………….………….. ….

Residing at House No…………Sub-district………..........District…………………………Province………………Tel…………………..……..………..…….

As the ❑Patient ❑Authorized proxy for Master/Miss/Mr./Mrs.:……………………..…………………….……DOB:……………..H.N…………….…….

Hereby has the intention of requesting for medical information that includes:

❑ Treatment Summary : ❑ Out-patient ❑ Inpatient Date of treatment: from…………………………..to……………………………………

❑ Photocopy of Medical Record/s: ❑ Out-patient ❑ Inpatient Date of treatment: from…………………………..to……………………………………

❑ Results of blood test report/ x-ray analysis result/ diagnosis result. Date:…………………………………………………………………………..

❑ Medical Certificate for consultation date:……………………………………………………………………………………………………….

Reason for the request:

❑ To claim for compensation from…………………………………

❑ To withdraw compensation from Social Security Office

❑ To withdraw compensation from Government, State Enterprise

❑ For benefit of further medical treatment at………………………

❑ To apply for insurance of…………………………….……………

❑ Others (please specify)…………………………….……………..

Preference: ❑ I will personally come to the hospital to redeem the records on date:……………………………………………. Time:…………..…………..

❑ Please send by mail to:…………………………………………………………………………...………………..……………….……………

❑ Please send by FAX to:……………………………………………..:Attention:………………..……..………………………………………………

(Remarks: To preserve confidentiality of medical information, HIV results can not be sent by fax or mail. Please redeem the results in person.)

I, hereby take full responsibility to all consequences that will occur from the disclosure of the above medical information, nor will use it to claim for any compensation from Bangkok Hospital Phuket.

In this regard, in cases where I have authorized another person to request for medical information on my behalf, it shall be then be considered that this letter shall serve as a power of attorney authorizing the person mentioned below as the person to act on my behalf in every respect.

Mr. /Mrs. / Miss:…………………………………………………………………..………..………who is related to me …………...……….…………………..

Identification Card/Passport/ Driving License #:………………………………..Residing at #……..Road….….Sub-district………………Tel.#........................

Unless otherwise revoked by patient or proxy, this authorization shall expire on the day the request has been filled.

Signed…………………………………….….Patient/ Patient's proxy

(………………………………………..)Date………………..Time…….

Signed………………………………………..Assignee

(………………………..…………..) Date…..…………Tiem……..

Receiving record: I have full, complete and correct document as requested in testimony where of I have here under sign my name as evidence.

Signed:…………………………………………….………………Patient / Patient's proxy

(…………………..……………..………..…………..)

Date……………………………Time……….

Remarks: (1) The patient's proxy means the legal representative of the minor (not exceeding 20 years or those who do not come off legal age by marriage), the custodian of the disability by court order. The trustee of quasi-disability by court order.

(2) Documents to be attached: signed photocopy of patient's passport/Thai identification card or driver's license.

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