



**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.