AVISENA
HEALTHCARE

AHC/MRD/059/V1/2024

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 SPECIALIST HOSPITAL 2**

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.