



# METRO SPECIALIST HOSPITAL

## LETTER OF AUTHORIZATION TO RELEASE MEDICAL REPORT

### PATIENT'S PARTICULARS

PATIENT NAME: \_\_\_\_\_

NRIC NO/ BIRTH CERTIFICATE NO/ PASSPORT NO: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CONTACT NO: \_\_\_\_\_

### TYPE OF APPLICATION [Please tick ]

- |  |  |
|--|--|
| 1. <input type="checkbox"/> Medical Report (Free Format) | 4. <input type="checkbox"/> Insurance Form |
| 2. <input type="checkbox"/> Specialist Report            | 5. <input type="checkbox"/> EPF Withdrawal |
| 3. <input type="checkbox"/> Lawyer Report                | 6. <input type="checkbox"/> SOCSO Form     |
|  | 7. <input type="checkbox"/> Others: _____  |

### AUTHORIZATION [Please tick ]

I, the above-named patient; or

I, \_\_\_\_\_ NRIC No/ Passport No  
\_\_\_\_\_ the next-of-kin of the above-named patient; or

I, \_\_\_\_\_ NRIC No/ Passport No  
\_\_\_\_\_ the legal representative of the above-named patient,

hereby authorize Metro Specialist Hospital and its staff to disclose my / the patient's medical report to :

\_\_\_\_\_  
Name of Individual or Company

I further undertake to settle all costs and expenses incurred and hereby absolve Metro Specialist Hospital and its staff from all responsibility and liability that may arise from this consent.

\_\_\_\_\_  
Signature/ Right Thumbprint of Patient

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Next-of-Kin OR

Signature of Legal Representative

Relation to patient: \_\_\_\_\_

Date: \_\_\_\_\_

**NOTE: This form must be signed by the Parents/ Guardian/ Next-of-Kin of the patient if the patient is under 18 years of age or is physically or mentally incompetent to consent to the release of information.**

### FOR OFFICE USE ONLY

Application received by:

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Staff: \_\_\_\_\_