

APPLICATION & CONSENT FOR RELEASE OF MEDICAL INFORMATION

Name: _____
 MRN: _____
 Date: _____
 IC No. / ID: _____
 Age / Sex: _____
 Bed / Ward: _____
 Affix Patient's label here. If no label, fill up accordingly.

DATE : _____ ATTENDING DOCTOR : _____

SECTION A: TYPE OF REPORT OR APPLICATION (Please tick accordingly)

- Insurance Form / SOCSO / EPF
 Medical Report
 Medical Report for Lawyer
 Medical Report for Police / KKM
 Laboratory Report
 Imaging Report
 Others: _____

SECTION B: REQUESTOR'S DETAIL

RELATIONSHIP TO PATIENT (Please tick accordingly):

- Self (Skip the rest of this section, continue to Patient's Particulars)
 Next-of-Kin
 Insurance Agent
 Others: _____

Requestor's Name: _____ NRIC/Passport No.: _____

Contact Number: _____ Email Address : _____

Organization (if applicable) e.g., Law Firm: _____

 (Requestor's Signature, Date)

SECTION C: PATIENT'S DETAILS

Name: _____ MRN: _____ Sex: Male / Female

Out-patient Date: _____

In-patient Date : Admitted from _____ to _____

Contact Number: _____ Email Address: _____

SECTION D: DELIVERY METHOD

- Self-Collect
 Email: _____
 Courier (Peninsular Malaysia: RM10, East Malaysia: RM20)
 Address: _____

SECTION E: DETAILS OF PAYMENT

METHOD OF PAYMENT:

- Payment made at KGSC (RM): _____
 Online Banking (RM): _____ Bank: _____

Note: A 20% levy will be imposed for a refund on the cancellation of medical report applications and no cancellation will be allowed once the report has been written by the Doctor.

SECTION F: CONSENT OF RELEASE

I hereby declare and confirm that I made this request freely, voluntarily and without coercion and that the information given above is accurate and true to the best of my knowledge and belief, and that the medical report is required for the purpose stated above. I understand that I may be liable for prosecution for making false declaration. Further, I undertake full liability, responsibility, duty to indemnify and release **KENSINGTON GREEN SPECIALIST CENTRE ("KGSC")** for any cost, legal proceeding, liability loss or damage incurred or suffered by anyone arising out or in connection with the release of the medical report shall subject to approval of **KENSINGTON GREEN SPECIALIST CENTRE ("KGSC")**, and I hereby authorize _____ (Representative's name) _____ (Representative NRIC/Passport No.) to collect the medical report on my behalf if ineligible to present.

ACKNOWLEDGED BY (Patient/Parent/Next-of-kin)

WITNESSED BY (Staff/Accompany)

 (Signature or Thumb)



 (Signature, Name, Date)