# Consent Form for Release of Patient Medical Information

Re: Mr. / Mrs. /Miss ..... H.N.....Date of birth .....

Age: .....National ID card/ Driving license/ other card is .....Number: .....

Home address:.....Street:.....

District:..... City:.....Country:.....Phone No.:.....

A certificate of the hospitalization in Bangkok Hospital Pattaya from date.....to.....is requested

Request: ☐ Medical treatment history – diagnosis, hospitalization and laboratory result

☐ Post -mortem/ Autopsy certificate

☐ Medical check-up report

☐ Claim form

☐ All films and report of X-rays and.....

☐ Other.....

☐ Doctor's certificate to claim government or State Enterprise benefits

Remark: _____

Request for patient information is by:

☐ Self

☐ Authorize/ Legal Guardian ..... .....

Name Relationship

National ID Card/ Passport No :.....

Address :.....

Telephone :.....

I acknowledge and understand that all medical patient information is confidential and secured by the Bangkok Hospital Pattaya and will only be released to an authorized person. Information that is collected by someone other than a BPH employee may be re-disclosed and is no longer protected by the hospital. This consent form authorizes others to proceed on my behalf.

Signature: .....Patient/Legal Guardian Signature:.....Authorized Person

_____ _____

**(Printed Name)** **(Printed Name)**

Documentation Request(s) for the following reasons:

- ☐ For a claim from insurance company
- ☐ For continuing medical treatment at (name of hospital)……
- ☐ For a compensation claim from Social Security
- ☐ For insurance application
- ☐ For a compensation claim from government and state enterprise office
- ☐ For a medical profile to be kept at my current company
- ☐ For pre-employment check-up
- ☐ Other (please specify)……

Documents to be collected by:

- ☐ Self/ Legal Guardian/ Authorized Person
- ☐ Mail to address:……
- ☐ Fax/ Fax No……
- ☐ Email, only medical check-up results may be sent by email:…….

Note: Faxed information will not contain HIV results, drug abuse or mental health treatment

I have received the patient medical information that requested.

**Signature:……**

**(…….)**

**Date ……..Time ……**

☐ Patient ☐ Legal Guardian ☐ Authorized Person

Note: Someone charged with the authority of the patient means the rightful representative of a patient less than 18 years old unless they have a marriage certificate. The Legal Guardian has been assigned by court order.

**FOR HOSPITAL USA ONLY**

Part 1: Document enclosed with the application

| The applicant | Documents |
|---|---|
| ☐ Patient | ○ Requesting application ○ ID card copy |
| ☐ The legal guardian | ○ Requesting application ○ Court orders ○ Death certificate ○ ID card copy of patient ○ Birth certificate ○ ID card copy of the legal guardian ○ Copy of Home Registration Book (In case of the patient doesn't reach the legal age or the parent's name are registered in Home Registration Book) |
| ☐ The authorized person | ○ Consent Form ○ ID card copy of patient ○ ID card copy of the legal guardian ○ Service fee baht (for insurance ☐ company) Cash ☐ Cheque from Bank ……..No. ……. |

Part 2: With requests for medical

information For staff's department

Doctor / …….

☐ Patient

☐ The legal guardian/ The authorized person Mr. / Mrs. / Miss……

Wishes to receive the requested medical information as per page 1

starting from: Date ……to……

Your approval is requested,

Name ……(Registration Staff)

(…….. )

Date ……..……Time……

○ Not Accept ○ Accept and should proceed as ……

_____

Physician / Designee

Date ……..Time……..