

**CONSENT AND AUTHORIZATION FORM
TO RELEASE PATIENT INFORMATION****PATIENT DETAILS:**

Full Name :

NRIC Number :

Phone Number : Date :

PARENTS / LEGAL GUARDIAN / NEXT OF KIN :

Full Name :

NRIC Number :

Phone Number : Date :

Relationship To
Patient :

I hereby give consent to AVISENA Healthcare to release my medical information and records for the purpose of **INSURANCE / MEDICAL REPORT / SOCSO / KWSP / MEDICAL CERTIFICATE (MC) / IMMUNIZATION REPORT / DISCHARGE SUMMARY / INVESTIGATION REPORT** or(please specify) including information related to the diagnosis and/or treatment received at AVISENA Healthcare.

(Please tick either one);

☐	AVISENA SPECIALIST HOSPITAL (ASH)
☐	AVISENA SPECIALIST HOSPITAL 2 (ASH2)
☐	AVISENA SPECIALIST CLINIC, CYBERJAYA (ASC)

I understand and acknowledge that the information released may contain confidential medical information relating to my diagnosis, treatment, investigations, and healthcare services received at AVISENA Healthcare. The information may be released to the representative named below :

REPRESENTATIVE DETAILS:

Full Name :

NRIC Number :

Relationship :

Phone Number : Date:

Signature of Patient/ Parent/ Legal Guardian /
Next of Kin

(Signature of Representatives)

*NOTE: This form is to be signed by the Parents/Legal Guardians/next of Kin /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.