

APPLICATION FOR MEDICAL REPORT AND CONSENT FOR RELEASE OF INFORMATION

1. I, _____ NRIC/Passport No: _____
wish to apply for a medical report / copy of investigation report.
2. Details of the visit are as follows:
- I. Patient Name : _____ (if differs from applicant)
- II. Medical Record Number : _____
- III. Visit Date : _____
- IV. Name of attending doctor : _____
3. Relationship of applicant to patient : _____
4. Type of Information / Report Requested :
- Hospitalization & Insurance Claim Form Discharge Summary EPF SOCSO
- Investigation Report Written Medical Report Critical Illness
- Others (*please specify*) : _____
(*Supporting document/s applicable*)
5. I hereby acknowledge I am aware that my personal data as defined under the Personal Data Protection Act 2010 (PDPA) is managed under CMC Group's Privacy and Personal Data Protection Policy, which is accessible at <https://subangjayamedicalcentre.com/privacy-and-pdpa-policy>.
6. I hereby consent and authorize **Subang Jaya Medical Centre** and its staff to disclose information (in full or in part) concerning the medical condition of myself / my child / parent / spouse to:
- _____
- (*A valid consent is to be duly signed by **patient / next of kin**, including in the case of a deceased patient.*)
(*A copy of the NRIC front and back of the representative is required / where applicable.*)
(*Child refers to below 18 years of age.*)*
7. I further authorize **Subang Jaya Medical Centre** and its staff to release this report to:
- Mr / Ms : _____ (Relationship) : _____
- NRIC No : _____ who will receive this report on my behalf.
(*Please attach a copy of the NRIC front and back*)*
8. I agree to indemnify CMC Group and its subsidiary which operates Subang Jaya Medical Centre (collectively, the CMC Entities) against any claims or liabilities which may arise in connection with release of information pursuant to and in reliance on my instructions and the consent given under this form. I hereby absolve Subang Jaya Medical Centre from any liabilities forthwith.

Signature of Patient/Parent/Guardian/Next of Kin

Signature of Applicant

Name: _____

Name: _____

NRIC/Passport No: _____

NRIC/Passport No: _____

Date: _____

Date: _____

Contact No: _____

Contact No: _____