Jerudong Park Medical Centre

Organization Accredited Joint Commission International

REQ NO.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Release of Medical Information

I, ______________________________ , NRIC No. ______________
(name)

of ____
(address)

hereby consent for Jerudong Park Medical Centre ("JPMC") to the release and disclose to the party stated below privileged personal information including medical information of the following person:

Name ______________________________ (PRN No.) ______________

The information relates to me / my spouse / my child / my ward *(Please delete whichever is not applicable)*

Please state the **purpose** for requesting file/information:

____

RELEASE RECORDS FROM

Jerudong Park Medical Centre

Jerudong BG3122 Brunei Darussalam

+673 261 1433 ext. 2139/2216

emr.info@jpmc.com.bn

www.jpmcbrunei.com

RELEASE RECORDS TO

Name / Organization

____

Address with Post Code

____

Phone no. ______________ Email ______________

Note for the requestor:

We may apply fees or charges per JPMC Charge Slip, but we will notify you of any applicable fees before we process your request.

- I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity.
- I understand that the records released may include information relating to Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug control or alcohol abuse; or mental or behavioral health or psychiatric care.
- I understand that this request is valid for SIX (6) months unless I notify JPMC otherwise. I may revoke this request in writing at any time except to the extent that JPMC has already relied on this request. I may revoke it by mailing or facing a written notice to Medical Records Department, JPMC, stating my intent to revoke this request.
- I understand that the information may no longer be protected once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.
- I unconditionally release JPMC from any responsibility and liability resulting or arising form the disclosure of the privileged information.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
- I hereby confirm that the information provided above are accurate, correct and complete and that the documents submitted along with this application are genuine.

______________________ Patient's Signature

______________________ Parent's / Guardian's Signature

______________________ Date & Time

______________________ Date & Time