Jerudong Park Medical Centre

REQ NO.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Release of Medical Information

I, _____ , NRIC No. _____
(Patient / Next-of-Kin / Guardian)

of _____
(Patient's 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.) _____
(Patient)

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	**RELEASE RECORDS TO**
Jerudong Park Medical Centre	Name / Organization
Jerudong BG3122 Brunei Darussalam	
+673 261 1433 ext. 2189 / (8) 1579	Address with Post Code
emr.info@jpmc.com.bn	
www.jpmcbrunei.com	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   Next-of-kin / Guardian's Signature

_____   _____
Date & Time   Date & Time