

**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**

Jerudong Park Medical Centre

 Jerudong BG3122 Brunei Darussalam +673 261 1433 ext. 2189 / (8) 1579 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 Health Information Management 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 from 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