โรงพยาบาลกรุงเทพ
BANGKOK HOSPITAL
พัทยา • PATTAYA

Consent Form for Release of Patient Medical Information

Re: Mr. / Mrs. /Miss_____ H.N. _____ Date of birth _____

Age: _____ National ID card / Driving license / other card is _____ Number: _____

Home address: _____ Street: _____

District: _____ City: _____ Country: _____ Phone No.: _____

A certificate of the hospitalization in Bangkok Hospital Pattaya from date _____ to _____ is requested

Request:
- ☐ Medical treatment history – diagnosis, hospitalization and laboratory result
- ☐ Post -mortem /Autopsy certificate
- ☐ Medical check-up report
- ☐ Claim form
- ☐ All films and report of X-rays and _____
- ☐ Other _____
- ☐ Doctor's certificate to claim government or State Enterprise benefits

Remark: _____

Request for patient information is by:

- ☐ Self
- ☐ Authorize/ Legal Guardian _____ _____
  Name relationship

  National ID Card /Passport No : _____

  Address: _____

  Telephone: _____

I acknowledge and understand that all medical patient information is confidential and secured by the Bangkok Hospital Pattaya and will only be released to an authorized person. Information that is collected by someone other than a BPH employee may be re-disclosed and is no longer protected by the hospital. This consent form authorizes others to proceed on my behalf.

Signature: _____ **Patient/Legal Guardian**

_____
(Printed Name)

Signature: _____ **Authorized Person**

_____
(Printed Name)

Documentation Request(s) for the following reasons:

- ☐ For a claim from insurance company
- ☐ For continuing medical treatment at (name of hospital)_____
- ☐ For a compensation claim from Social Security
- ☐ For insurance application
- ☐ For a compensation claim from government and state enterprise office
- ☐ For a medical profile to be kept at my current company
- ☐ For pre-employment check-up
- ☐ Other (please specify) _____

Documents to be collected by:

- ☐ Self/ Legal Guardian/Authorized Person
- ☐ Mail to address: _____
- ☐ Fax/ Fax No. _____
- ☐ Email, only medical check-up results may be sent by email: _____

Note: Faxed information will not contain HIV results, drug abuse or mental health treatment

I have received the patient medical information that I requested.

Signature: _____

(_____)

Date _____

☐ Patient ☐ Legal Guardian ☐ Authorized Person

Note: Someone charged with the authority of the patient means the rightful representative of a patient less than 18 years old unless they have a marriage certificate. The Legal Guardian has been assigned by court order.

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For hospital use only

Part 1: Document enclosed with the application

The applicant	Documents
☐ Patient	○ Requesting application ○ ID card copy
☐ The legal guardian	○ Requesting application ○ Court orders ○ ID card copy of patient ○ Death certificate ○ ID card copy of the legal guardian ○ Birth certificate ○ Copy of Home Registration Book (In case of the patient doesn't reach the legal age or the parent's name are registered in Home Registration Book)
☐ The authorized person	○ Consent Form ○ ID card copy of patient ○ ID card copy of the legal guardian ○ Service fee _____ baht (for insurance company) ☐ Cash ☐ Cheque from Bank _____ No. _____

<u>Part 2:</u> With requests for medical information

For staff's department

Doctor / _____

☐ Patient

☐ The legal guardian / The authorized person Mr. / Mrs. / Miss. _____

Wishes to receive the requested medical information as per page 1

starting from: Date _____ to _____

Your approval is requested,

Name _____(Registration Staff)

(_____)

Date _____

○ Not Accept ○ Accept and should proceed as _____

_____

_____

Physician / Designee

Date _____